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An Address.¹

MEDICINE—MAGIC OR MIRACLE?

By H. G. JUDKINS,

Retiring President of the Victorian Branch of the British Medical Association.

Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible.

—SIR WILLIAM OSLER.

BEFORE launching into the subject which I have chosen as my swan-song this evening, I must express my sincere appreciation of the opportunity given to me twelve months ago of both leading and serving the Council and members of this Victorian Branch of the British Medical Association. It has been an exacting but exciting year, in which the medico-political climate has been "hot and stormy", and in which the progress towards the formation of an Australian Medical Association has been steady and satisfactory, but not without its problems.

¹ Retiring president's address, delivered at the annual meeting of the Victorian Branch of the British Medical Association on December 7, 1960.

It has been a year in which I have made many new and lasting friendships, and have been met with consideration, courtesy and encouragement from the members of the Council, from those in high places, and from the rank and file of the profession. It would not have been possible for me to accept this position without the generosity of my partners in releasing me from so much work in our practice and cheerfully carrying the added burden involved. I can only say to one and all, thank you for a privilege and an honour which in my wildest dreams I would not have thought possible.

In the year 1925 I went to the D'Entrecasteaux group of islands in Papua to take up medical work for the Methodist Church in that area and to supervise the building of the hospital at Salamo. At that time there were only three Government medical officers in the Territory, stationed at Port Moresby and Samarai, where there were both European and native hospitals. The only medical work being carried out in the vast outlying areas of the Territory was that done by missionaries, missionary sisters and Government patrol officers, and was largely confined to hygiene, child and infant welfare and first-aid treatment. Much of this may have been done on the principle of "aspirin for complaints above the waist and Epsom salts for those below"; but no words of commendation for the work that was done by these devoted people under difficult conditions could be too praiseworthy.

As an endeavour was made to extend the medical work, and by hospital treatment and patrol services to bring the benefits of modern medical knowledge to these primitive people, I became very aware of the handicaps imposed by strange customs, and was brought face to face with the fantastic power of magic in this primitive community and its evil influence on the life and health of the people.

Every native Papuan in that area carried a lime-gourd, in which he kept lime to be used in the common practice of chewing betel-nut. The end of his lime-stick (usually made of ebony) was thus coated with a dried mixture of lime, betel-nut and saliva. The blackest of black magic known as Sumwana was practised by the scraping of this stick by a sorcerer.

About the time of my arrival in Papua, a young man of some 35 years of age named Cockroach was the head man of the island of Dobu. (It was not an uncommon practice among these people for some English word which fascinated them to be added to the native names already possessed.) He had travelled one morning with nine other men in a large canoe to a neighbouring island to garden. On returning in the evening for the homeward journey, he noticed that his lime-stick, which he had left in the canoe, had been scraped. He immediately felt ill and told his friends that he was not well enough to paddle home. Arriving at Dobu, he went into his house a sick man. The scrapings which had been taken by a well-known sorcerer were given to the people of a village which had suffered at the hands of Cockroach's uncle, the former chief of Dobu, in cannibal raids years before. One evening a great feast and dance of revenge was held in that village, during which an effigy of Cockroach containing the scrapings was crushed between two stones. The same night on the island of Dobu, Cockroach died—seventy-two hours after he had been "sorcerized".

The whole social and communal life of the primitive Papuan was bound together by a network of custom, legend and taboo, which had as its foundation fear, superstition and magic. What for the want of a better term might be called "good magic" served to maintain some semblance of law and order within the community, but the evil magic was used to produce illness and death and for personal revenge.

The primitive man believes that nothing happens by chance. There is a symbolic significance in everything that occurs about him and in everything that happens to him. His whole life is spent in fear lest at any time he offend one of the evil spirits or become the victim of the sorcerer's power. He cannot conceive cause and effect as we know it in the production of disease and ill health. In his mind there is no place for accidents. They do not just happen, but are the result of some breaking of taboo or custom, or the result of the influence of evil magic. For instance, there is a taboo which prevents stealing of coconuts because it prohibits a man by fear of death from climbing another's coconut tree. If he does break this taboo, the native believes he will fall from the tree and be killed. If he falls from his own tree it is again not an accident, but the influence of evil magic.

The same belief is true of disease. Except in the case of very old people, there is no natural cause for illness or death. It can be only the result of some sinister, well-recognized action of some other person, or the work of the sorcerer or the breaking of taboo. So deeply ingrained is this in the mind of the primitive man that it is not possible just to laugh it off or to endeavour to show him how foolish it is.

I had a rather embarrassing experience one evening while sitting on an upstairs balcony of the hospital with the matron and staff. There was a commotion on the stairway as a work-boy from the inland region of Salakahadi was pushing before him a smaller boy who had arrived only that day from a coastal village. They had been sitting round the fire having their evening meal when the new arrival, who had his dilly-bag over his shoulder, gave it a hitch, and the business-end of his bamboo comb stuck into the arm of his neighbour. In the Salakahadi region this was an act of sorcery, and the work-boy was angry, because he would be sick next day. In an attempt to show him the foolishness of his belief as the result of what was obviously an accident, I took the comb, poked the matron with it, and asked him if he believed she would become ill. He assured me that she would. The next

morning the work-boy was unable to work, and to my chagrin the matron was ~~in~~ bed with an attack of malaria.

With this deeply rooted belief as the background to illness, the coming of the "white man's medicine" produced some problems. It was quite natural for the native to assume that the doctor who could cure an illness with a dose of medicine or an injection must have some magical power; so the doctor, coming to the aid of these people in their tragic plight, was in danger of being put side by side with the witch-doctor (although certainly in superior class). I remember well a young man who sought admission to the hospital because of severe constipation caused by the evil magic of the sorcerer. He had heard that my magic was stronger than that of the sorcerer, but, on recovering, was afraid to leave the hospital because again the sorcerer's power would afflict him.

The primitive man can, of course, have no knowledge of the scientific progress of medicine over the years, no knowledge of the results of years of research, no knowledge of the training that enables a doctor to recognize a disease, to understand its cause and treat it with appropriate drugs. To every medical success he must attach an explanation in terms of magic.

I well recall my first anaesthetic given for a simple procedure. This was done with quite an audience, in the hope of thereby gaining the confidence of the people. It was not long before the news spread through the villages that the doctor had made a man die, cut his flesh and then brought him back to life again.

The whole world of the primitive man is a playground of magical beliefs, some evil and some good, that control his actions, influence his health and order his life.

Let us move now from the primitive man to the modern man in the environment of a civilized community. He believes in cause and effect. Medical research has taught him that bacteria and viruses cause disease and that certain dietary deficiencies cause ill health. He knows that accidents can happen, and that no black magic is involved. But in the subconscious mind there remains the influence of magic. Tournier, to whom I am indebted for some thoughts on this subject, reminds us that "the primitive mind seems strange to us only because we have pushed it down into the subconscious—but it is still there".

In a Papuan village there was one man who was the netmaker. He alone was able to put that magic into the net that would make it effective in catching fish. But is this, after all, very different from the influence that the black cat or the four-leaf clover holds over the actions of countless people in a civilized community? Or the superstition, and even fear, that many people have about starting a journey or commencing a new venture on Friday the thirteenth?

One afternoon, some years ago, a city business man entered my consulting-room seeking my advice about his rheumatism. Leaving my rooms with a prescription (which may or may not have been useful), he was crossing the road when he met my father, who asked him how he was. "I have just been visiting your son to get some treatment for my rheumatism", he said. My father replied that he was sorry to hear he was not well, and said that he also was bothered with some rheumatism in his wrist. My patient then said: "I can tell you what will cure it, Mr. Judkins. Get some black twist—it must be twist, not cotton—and wind it round and round your wrist two dozen times. That will quickly cure you."

There was a time when medicine (such as it was) and magic were closely related, and men lived in a world of superstitious beliefs. At the very beginning of the era of scientific medicine, there existed in the physician both the alchemist, searching for the elixir of life—the magic potion that would charm away the illness and suffering of life—and the scientist. Since then, scientific medicine has developed as research has opened up new fields of knowledge, especially during the past 50 years, leaving the field of magical medicine to pseudo-scientific and non-scientific fields of thought. And there are many people who, finding their illness not relieved or too slowly cured, have recourse to this pseudo-medical practice which flourishes on the

superstitious mind of man and his subconscious belief in magic to this day.

I recall a witch-doctor in Papua treating a native man for bronchitis. He vigorously rubbed the man's chest on several occasions, and then, during one treatment, when the man was obviously improving, dropped a two-inch nail with a piece of red tape attached on the floor with the exclamation "Now you will be all right. That was the cause of your illness."

But a few years ago, here in Melbourne, a patient of mine with biliary colic was discovered at X-ray examination to have gall-stones, for which she refused operation. I did not see her again for some weeks, but one day she appeared and told me that she had been treated by a man who assured her that if she took his herbs and medicine she would pass the stones, and to prove it she produced a bottle with a dozen or so soft round objects about the size of marbles.

It is only a step from here to the reading of the palm of the hand, the dangling of some metallic object over the body or the acceptance of some panacea for all disorders to which the human frame is heir. It is certainly true that scientific medicine has not entirely freed man from this belief in the magical. It is equally true that scientific medicine alone will not bring man freedom from disease and ill health. "I dressed the wound, God healed him" has often been quoted, to recognize the association of scientific medicine with the healing power of God through nature, but it does not, I believe, represent the final miracle of medicine.

Medicine for long has been the medicine of disease. The long, patient, painstaking search for the cause of disease has made it so. To achieve its final success, it must become the medicine of the person. What is this medicine of the person? Tournier writes: "It is the medicine which at the same time as it tries to cure the disease by all the technical means that science puts at our disposal, tries to create in man that full harmonious development which will make him a person." In other words, man is not merely a physical and physiological machine. "I dressed the wound, God healed him" is not the final answer.

There is a physical problem—the man may have a broken leg to be set. There is a psychological and social problem—he is the bread-winner for the family, and the economic situation creates anxiety and worry. There is a spiritual problem—he bears resentment to the car-driver who hit him, and most probably towards God, posing the age-old question: "Why did this have to happen to me?"

Here, very simply, is the need for the medicine of the person. In order that he shall be really healed, his whole person has to be integrated. The doctor must take an interest in the patient as a whole and not in his symptoms alone. He must be physician, adviser and friend. It is at this very point, I believe, that much of our medical training and practice falls short of complete fulfilment.

Look for a moment at our medical education. Every teacher, lecturer and professor regards his particular basic science as of great importance, and more and more material is added each year to the vast store of knowledge. In clinical years there is more and more scientific training, more and more biochemical testing, more and more mechanization of medicine, until patients are in danger of becoming guinea-pigs on whom a diagnosis is finally reached by a process of almost endless elimination. All of this, I know, is tremendously important; but there is a grave danger of medical students and graduates thinking in terms of disease in a person, rather than of a person with a disease. There is much in our training that would support the statement that the undergraduate course in medicine is a "corpse-centred curriculum".

Hospital practice today tends to become very impersonal, particularly in the larger hospitals. There should be developed in a hospital an atmosphere that breathes kindness and consideration, understanding and sympathy, from the inquiry desk to the medical superintendent. It is a frightening experience to many people to enter a hospital. There is apprehension, a fear of the unknown, a lack of knowledge of what is going to happen; an absence, very often, of any explanation of medical or surgical procedures which prepares the patient for the

ordeal that lies ahead of him. To many people there is a feeling of loneliness, an atmosphere of separateness in a hospital ward. They have been lifted out of a domestic situation and placed in a new environment—separated from relatives, friends and often their own doctor. There will probably be an attitude of acceptance of this new situation, even a blind and bewildered submission to it—so much so that to some people the operating theatre is a chamber of mystery, in which they associate the white-gowned surgeon with the benevolent witch-doctor and the scalpel with the fairy wand. Dr. J.-R. Gosset of France, in an article on "Ideal Relationship", has expressed this experience in these words: "Hypertrophy of authority and science bring an impersonal and almost cruel coldness into medical care."

The inquiry-desk attendant should be alert to the feelings and fears of people who pass through her hands on the way to hospital beds. She should be responsive to the joy and happiness of the young father who walks through the door with brisk and excited steps, and should have a sympathetic understanding of the anxiety of the woman who comes fearfully because she has received an urgent call from the hospital telling her that a loved one is on the critically ill list.

Every member of a hospital staff has a part to play in the medicine of the person—the waitress bringing in the morning tea, the aide who arranges the flowers, the nurse who does the most unpleasant tasks with a good will, the orderly wheeling the patient to the operating theatre and the almoner discussing and solving problems of home and after-care. All these and many others make a contribution to the attitude of the patient to his ultimate recovery.

The danger of becoming impersonal must remain a continuous challenge. The regularly changing staff, particularly in a labour ward, can disturb the confidence of a mother, and calls for the closest cooperation between staff members. It is not infrequent, in asking a question about a patient in a ward, to be told by the nurse: "I'm afraid I have been off duty for two days and haven't caught up with the patients yet." What is the influence of this remark made in the presence of a sick person? It is, I believe, vitally important that each patient is made to feel that he is the only person that really matters.

Just how far the mechanism of body metabolism, and the process of disease and recovery, are affected by the attitude of doctor and nurse may be a matter for further research; but it was interesting to hear at a recent symposium in this hall, on toxæmias of pregnancy, that it would appear that preeclampsia is more common when a patient has been examined ante-natally by a number of different doctors, and is less common when a patient has been made to feel that she is the only person who matters, and has the skill, understanding and devotion of her doctor willingly at her disposal. This is an important aspect of the doctor-patient relationship, whether at the specialist or general practitioner level, whether in private or hospital practice.

We live in a world of hurry, where doctors are often pushed by the weight of work; but medicine will achieve its completeness only when personal contact with patients is in a calm and unhurried atmosphere. The task of the doctor is to attend and cure his patient, and to do this he must know not only his medicine but his patient. It is tremendously important for the doctor to put himself on the level of those under his care, and to approach each patient with an alert and open mind, ready for some word which may reveal a hidden problem. It is easy to see a patient four or five times and get only a superficial view of his symptoms. It is easy to put a patient through the hoops of investigation without ever having an awareness of his basic problems and need.

It is true that for many of these patients the specialist psychiatrist is the only answer. I would entirely agree with the Reverend Principal Greeves who, in a recent work, wrote as follows:

Psychiatry has passed beyond the stage at which it is possible for a non-professional to gain adequate knowledge. The day has arrived when only a fully

medically-trained psychiatrist can be trusted to be in charge of such work, however many workers trained in other sciences are needed as auxiliaries.

On the other hand, any doctor who has the whole health of his patient on his heart, cannot fail to be interested in psychiatric work and to some extent involved in it. He must learn to seek and to understand his patients' basic needs and anxieties and, identifying himself with these difficulties and problems, help him to solve them.

I am thinking of a young woman who developed tuberculosis some years ago, and who entered a sanatorium under great mental stress because this necessitated separation from her husband and her young family. She made a complete recovery and returned home. A few months ago, she sat opposite me in my consulting-room, tired and nervous, saying that she had failed twice to get her driving-licence and was trying again; could I give her something to "buck her up"? Physical examination gave completely negative results. She returned six weeks later again, tired, irritable and moody. She had succeeded in securing her licence; and then, in response to a simple question, she talked for one and a half hours about a situation that had existed in the home since her marriage—a husband, who was devoted to her, but whose mother had influenced his thinking and had sought to dominate the lives of her children. She passively accepted this situation in which she and her children were involved, but of which she was fearful. At the end of our time together she went away believing that she could better face and cope with that situation, happy because I now appreciated her earlier reluctance to leave her family for medical treatment, and because—to use her own words—"someone listened and understood".

We live in a world of men and women whose lives and whose health are influenced, not only by physical, physiological and psychological factors, but by spiritual forces. This is an ancient truth that is being rediscovered by modern medicine, and put into action in the doctor-psychiatrist-minister team. Just as there is an overlapping area in the physical-psychological field of medicine, so is there an overlapping area in the physical-psychiatric-spiritual field. Just as it is not the duty of the physician to usurp the place of the psychiatrist, neither is it the duty of the doctor to usurp the place of the minister or priest. But it is here that the well-equipped physician, surgeon or psychiatrist will be alert to the spiritual problems underlying or associated with his patient's illness, and be ready to seek the help and cooperation of the specialist in this field—the spiritual counsellor. The increasing anxieties and tensions of modern living put a new responsibility on the doctor. If he is willing—and takes the time—to listen with an open mind to his patients' problems, he will find himself not only unravelling domestic and social difficulties and uncovering emotional causes, but involved in spiritual problems and conflicts.

The primitive Papuan had a threefold conception of man as body, shadow and spirit. After death, his body was often buried with his head above ground, and the skull was subsequently kept in a skull house and carried in an occasional skull dance; his shadow remained over the village in which he lived and exercised an influence, usually evil, over the minds and lives of the people; his spirit went to the spirit world at the summit of one of the high mountains, Bwebweso, and there entrance was gained on the standards of health and material attainments. Was this a primitive conception of the physical-mental-spiritual relationship in sickness and health, in life and death?

Nearly two and a half thousand years ago Plato said: "If the head and body are to be well, you must begin by curing the soul." This ancient truth is becoming increasingly evident today. We must accept and use all the medical and surgical skill that is available, all the achievements of modern research, to maintain and recover physical and mental health, and all the spiritual forces available to man if the miracle of medicine is to be accomplished.

And so I come back to my question: medicine—magic or miracle?

In his well-known work, "A Doctor's Case Book", Tournier wrote:

The spirit of magic lies in wait for all of us. It is the longing for the fairy tale, for the magic wand that will charm away the difficulties of life, the suffering, the limitations, the uncertainties of our human condition.

That spirit of magic will be transformed to miracle only as we acknowledge that there are needs and problems, fears and conflicts which exist not only in the mind, but in the soul, of man, and which relate to his health.

There is much to be said for the statement that a miracle is the outward sign of the working of laws which we do not understand. Geoffrey Hoyland, in his book "The Great Outlaw", writes that miracles are "signs"—plain indications that a spiritual world with a law and pattern of its own exists behind this world of matter. Sometimes—this spiritual world can impose its pattern masterfully upon the world of matter just as a great magnetic crane in a steel works can make nonsense of the law of gravitation. But these things are not miracles that lie outside all pattern; they are the signs of a different pattern which man must learn to incorporate into his understanding of the world".

In all this the doctor has a vital and important part, if he is equipped to use all the remedies at his disposal and is willing to accept all the forces of healing which are available to him.

One morning, on my visiting round, I was passing the house of a patient whom I occasionally visited, when a sudden urge compelled me to stop and enter the house. I had just been shown into the patient's bedroom when the daughter of the house returned and said that her father wanted to see me at once. He had a physical disability and an anxiety neurosis as a result of war service. I found him in the laundry, and at the moment when I had rung the door-bell he had cut his wrist in a suicide attempt. Out of that experience there came a man healed mentally and spiritually, able to live with and overcome his physical disability. Some will say it was chance and some that it was fate; but some will see in it the hand of God.

Physical recovery, mental restoration and spiritual regeneration all bring man nearer to that perfect health which is God's will for him.

If we are content to fight against disease and ill health and suffering in the arena of the body and mind only; if we fail to carry the battle for perfect health into the spiritual arena; if we fail to sow the seeds of hope where there is despair, and of trust where there is fear; of love where there is hatred and of faith where there is doubt; then we shall for ever remain in the realm of "scientific magic", where the achievements have been undeniably great, but where the "fairy-tale" is still the fascinating mystery story of the laboratory and the "magic wand" is to be found in the power of the scalpel, and we shall never really accomplish the miracle of making men whole which, I believe, is the final duty and supreme task of medicine.

SOME FACTORS IN THE PREVENTION OF SEPSIS IN OPHTHALMIC SURGERY.¹

By D. O. CROMPTON, F.R.A.C.S., D.O.,
Honorary Ophthalmologist, Royal Adelaide Hospital.

IN this paper I have attempted to correlate the data embodied in two previous articles (Crompton, 1958 and 1959) with those of Anderson (1958) and Jeffs (1959). In it various potential causes of ocular sepsis are stressed.

Table I embodies possible aetiological factors to be considered when one is investigating a case of post-operative sepsis. Many of these predisposing factors were demonstrated in the course of this investigation. It may not be generally realized that air-cooling apparatus is a potential hazard (Anderson, 1959).

¹ Read at the first congress of the Asia-Pacific Academy of Ophthalmology, Manila, October, 1960.

Incidence of Serious Post-Operative Infection in Adelaide.

Personal Cases.

A list of various consecutive operations performed by me during the years 1948 to 1960 is shown in Table II. Operations for such conditions as dacryocystitis, entropion or traumatic perforation of the eyeball are omitted. Immediate panophthalmitis did not follow any of the

TABLE I.
Factors Predisposing to Ocular Sepsis.

Source.	Table IA. Endogenous Factors.		
	Local Sepsis.	Remote Sepsis.	Other Diseases.
The Patient.	Blepharitis. Styes. Conjunctivitis. Dacryocystitis.	Dental sepsis. ¹ Uro-genital sepsis. ¹ Other infective conditions.	Diabetes mellitus. ¹ Debilitating diseases. Avitaminosis. Chronic alcoholism. Senility. Mental disease. ¹

Table IB.
Exogenous Factors.

Source.	Table IB. Exogenous Factors.		
	Animate. ²	Inanimate.	
The ward.	Doctors. Nurses. ¹ Wardmaids. Visitors.	Dressings. ¹ Drops. ¹ Instruments. ¹ Blankets. Dust. Towels.	Solutions. ¹ Soap. Scrubbing brushes. ¹ Face masks. ¹
The theatre.	Doctors. ¹ Nurses. ¹ Attendants. Technicians.	Dressings. Drops. Instruments. Dust. Sterile water. ¹ Air-cooling apparatus.	Towels. ¹ Solutions. Sutures. Talc powder. Face masks. ¹ Autoclave. ¹

¹ These factors were incriminated in the present investigation.

² Animate infection may be by droplet, errors in technique or contagious skin disease.

1411 operations and only two eyes were removed as a result of the 871 private operations. In one case conjunctivitis developed 15 weeks after a trephine operation, and

TABLE II.

All Operations of Specified Type Personally Performed in Seven Hospitals from 1949 to 1960.

Operation.	Private.	Adelaide Children's Hospital.	Royal Adelaide Hospital.	Total.	Resulting Eviscerations.
Squint correction	483	150	5	638	0
Glaucoma	111	18	113	242	0
Lens extraction	222	0	197	419	0
Needling	40	6	15	61	0
Curette evacuation	7	0	6	13	0
Keratoplasty	1	0	2	3	0
Operation for detachment of retina	7	2	26	35	0
 Total	871	176	364	1411	0

subsequent panophthalmitis necessitated evisceration of the eye. In the second case, despite a trephine operation eight months previously, an eye developed absolute glaucoma which necessitated its enucleation.

The dire results of panophthalmitis after cataract extraction are shown in the example of phthisis bulbi illustrated in Figure I.

Public Hospital Cases.

In Table III are listed eight cases of evisceration and one of enucleation following 1321 consecutive lens extractions at a public hospital in Adelaide. As I pointed out in my previous paper, these results compare favourably



FIGURE I.

This man had a lens extraction in South Africa. Subsequent panophthalmitis led to phthisis bulbi. He refused enucleation.

with similar series of cases elsewhere (Duthie and Foster, 1949), but a further search of the literature has revealed 7662 cataract operations which resulted in only six cases of endophthalmitis (Locatcher-Khorazo, 1956).

TABLE III.

Serious Infections Resulting from 1321 Lens Extractions Performed at a Public Hospital from 1949 to 1960.

Surgeon.	Number of Lens Extractions.	Resultant Infections Necessitating Operation.			
		Evisceration.	Case.	Enucleation.	Case.
Honorary surgeon :					
A	80	—	—	—	—
B	86	I	1950	—	—
C	41	—	—	—	—
D	89	II, VI, VII	1954, 1956, 1953	—	—
E	46	—	—	—	—
F	170	V	1957	—	—
G	31	—	—	—	—
H	83	—	—	—	—
I	104	III	1955	VIII	1954
J (Crompton)	197	—	—	—	—
Clinical assistant or registrar :					
K	117	IV	1956	—	—
L	3	—	—	—	—
M	3	—	—	—	—
N	27	—	—	—	—
O	17	—	—	—	—
P	7	—	—	—	—
Q	5	IX	1958	—	—
R	30	—	—	—	—
S	81	—	—	—	—
T	32	—	—	—	—
U	54	—	—	—	—
V	11	—	—	—	—
W	7	—	—	—	—

Further consideration of our nine cases indicates that intraocular infection is more likely to occur in diabetics and also in those cases in which lens protein escapes into the eye.

Table IV combines two previous tables, one of which gives the reasons for 280 consecutive enucleations and the other those for 64 consecutive eviscerations at a public hospital during the years from 1949 to 1958. Eight of

the 13 eyes lost after lens extraction came from the series of 1077 consecutive lens extractions performed at this public hospital, while the remainder were the sequel to lens extractions performed elsewhere. It will be noted that 30 patients lost an eye as an outcome of planned surgery, but 16 of these were late infections after operation for glaucoma.

Some may believe that these results are good, but it must be remembered that not all infected eyes are replaced by a prosthesis. Many not listed here are retained as uncomfortable organs with little useful vision and serve as a constant reminder to the ophthalmologist of a possible outcome of intraocular sepsis.

TABLE IV.

Incidence of Panophthalmitis in 344 Consecutive Enucleations and Eviscerations Performed at a Public Hospital from 1949 to 1958 Inclusive.

	Event or Condition Preceding Operation.	Enucleation.	Evisceration.	Total.
Infected eyes¹				
Lens extraction	..	4	9	13
Keratoplasty	..	0	1	1
Trephine or iris inclusion	..	8	8	16
Remote infection	..	1	2	3
Penetrating wound	..	0	21	21
Perforating ulcer	..	12	12	24
Inadequately treated foreign body received from an emery wheel	..	1	0	1
Total	..	26	53	79
Non-infected eyes	—	251	10	261
Case notes missing	—	3	1	4
Grand total	..	280	64	344

No case of sympathetic ophthalmia occurred.

Sources of Contamination.

Infected Eye Drops.

As an example of a retained (though now useless) eye I recall a man of middle age, whose left eye had been blind for 30 years. He reported to this hospital in 1957 because of a trivial corneal ulcer in the right eye. As it was his only useful eye, he was admitted to hospital and the lesion was iodinized. Two days later, as the cornea had become infected, a swab was cultured which produced a growth of *Pseudomonas pyocyanea*. By the following day the change was so great that it seemed obviously to be the result of treatment. Accordingly, instructions were given that the drops used for this iodinization should be cultured. The 5% cocaine drops that were used to neutralize the iodine grew the same organism.

Treatment was ineffective, and Figure II shows the ultimate result—a vascularized leucoma in a soft eye. Subsequently glaucoma developed.

Immediately after giving his report of the contamination of the cocaine eye drops, the medical bacteriologist, Dr. K. F. Anderson, was asked to investigate the ophthalmic ward, with the following results.

A heavy growth of *Ps. pyocyanea* was obtained from cultures of eye drops, including homatropine and cocaine, atropine (1%), carbachol, homatropine (2%), hyoscine (0.5%), hyoscine (0.25%) and "Lachesine". A heavy growth of this organism was also obtained from cultures of the foreign-body instrument spirit and the transfer forceps spirit. A coagulase-positive staphylococcus was produced by culture of swabs of the "Dettol" bowl and the nail-brush. Swabs of seven tubes of miscellaneous ointments and seven bottles of miscellaneous drops produced no growth when cultured.

It will be noted that there were more solutions profusely contaminated than sterile.

Defects in Aseptic Technique.

Further investigation disclosed that the principles of asepsis were not understood by the nursing staff. For example, a bottle of atropine drops from the dispensary would be obtained with a cork in place. The cork would

be removed, and an ordinary rubber-topped glass dropper inserted. The dropper would remain loosely in the bottle for weeks or even months, so that air contamination was inevitable. The method of dealing with the "Dettol" bowl and nail-brush was to replace the fluid daily but never to boil the bowl or brush. The dishes for the foreign body instruments and transfer forceps were similarly treated, while the dish lids were often left off for hours.



FIGURE II.

A vascularized leucoma in a soft eye resulting from the instillation of cocaine drops that were profusely contaminated with *Ps. pyocyanea*.

Doubtless you will agree that sufficient cause for the contamination had been found, but the fact that from so many solutions *Ps. pyocyanea* was grown prompted me to investigate the conditions in the dispensary. I took six bottles at random from the out-patient department's dispensary. These bottles had all been prepared in the same manner as those delivered to the ward. No growth was produced by cultures from five types of drops. These were: boric, adrenaline and zinc drops; pilocarpine (2%); eserine (0.5%); sulphacetamide (10%); and sulphacetamide (30%). However, atropine (1%) drops when cultured produced a growth of *Ps. pyocyanea*, and it was found that the cork from the bottle was heavily contaminated with the same organism.

It was evident that drops supplied to the ward and out-patient departments were not always sterile. In consequence, I took to the bacteriologist all the solutions in the ophthalmic out-patient department. Of 42 miscellaneous ophthalmic solutions received, 38 produced no growth when cultured on blood agar. A heavy growth of *Ps. pyocyanea* was obtained from the stock bottle of fluorescein (2%) and from small bottles of hyoscine hydrobromide (0.25%) and atropine (1%). A coagulase-positive staphylococcus was yielded by the mercurochrome (2%) solution and a solution of penicillin was heavily contaminated by a mould which did not grow at 37°C.

It was beyond dispute that the ophthalmic department was using many contaminated solutions.

Infected Sterilizing Solution.

The recovery of *Ps. pyocyanea* from instrument spirit emphasizes the danger when alcohol is used without the addition of a bactericidal substance. It is not widely known that the bactericidal property of a 70% solution of alcohol is critically related to the alcohol concentration. Any slight variation on either side of 70% results in a considerable loss of activity. Absolute alcohol, for example, has virtually no bactericidal properties. Changes in concentration may occur as the result of evaporation during hot weather or by dilution with water from wet instruments placed in the alcohol. We have found that the addition of cetrimide and chlorhexidine to the 70% alcohol solution produces an efficient instrument-storage solution with a wide spectrum of antibacterial activity. Variations in alcohol content are of less consequence in the presence

of these two substances, which are also compatible with the sodium nitrite incorporated for rust prevention.

Infected Scrubbing Brushes.

The only safe method of eradicating infected scrubbing brushes is to have a supply of autoclaved brushes in autoclaved containers.

Methods of Controlling Infection from Eye Drops.

Anderson has stated that eyedrops may be infected either by the replacement in a bottle of a dropper contaminated by contact with an infected eye or by the use of cork closures. Since the original description by Lowbushy (1951), the dangers of corks have been repeatedly emphasized. Anderson and Keynes (1958) have recently been able to demonstrate that the manipulation of such infected closures can release a shower of infected dust on to the surface of the liquid below. Wards and dispensaries must therefore replace cork by rubber, plastic or glass.

The action taken in this hospital was to replace all bottles of eye drops by "Bijou" bottles with metal screw caps containing a black rubber liner. The solutions were either autoclaved or sterilized by filtration, and as an additional precaution, the chlorbutol base was changed to one containing one part per 20,000 of chlorhexidine in saline or phosphate buffer. Tests showed that the solutions were arriving in the wards in a sterile condition. In the ophthalmic ward, the nurses were instructed to use a separate glass dropper and rubber teat for each treatment, and to boil both of these before and after use. Nurses were also instructed to draw up sufficient solution into the dropper to complete the treatment, so that the dropper did not have to be reinstated into the bottle, and any solution remaining in the dropper was to be discarded. In this way, the danger of infection was reduced to an absolute minimum.

Preparation of Eyedrops.

Jeffs (1959) has stressed the necessity for an improvement in the technique of preparing and administering eye drops. His investigation at this hospital revealed these drops to be a potential source of infection because (i) the bacteriostatics used were not always effective, (ii) the eye drops were not sterilized before being issued, and (iii) the volume of eye drops supplied was excessive and later they became contaminated in various ways.

Lowe (1954) has pointed out the disadvantages of various bacteriostatics. K. F. Anderson, in a personal communication (1959), states that of 15 clinical strains of *Ps. pyocyannea* isolated, all were killed by a 1 in 6000 solution of chlorhexidine in a test period of 15 minutes. The reason for testing so many strains was the notoriously variable sensitivity of individual strains of *Pseudomonas*. Additional tests have shown that chlorhexidine diacetate ("Hibitane") in a strength of one part per 20,000 is an effective bacteriostatic against *Ps. pyocyannea* and *Staphylococcus aureus*, which are the principal causative organisms of secondary infections in hospitals.

Chlorhexidine diacetate in a strength of one part per 20,000 has been found to be compatible with most ophthalmic drugs used, with the exception of fluorescein sodium and brilliant green. To render drops containing chlorhexidine isotonic, a phosphate buffer was selected. The formula for this vehicle is as follows:

Chlorhexidine diacetate	1 in 20,000
Sodium chloride	520 mg.
Sodium dihydrogen phosphate	520 mg.
Disodium hydrogen phosphate	1180 mg.
Distilled water (fresh and pyrogen-free) to 100 ml.	

This vehicle is compatible with amethocaine, atropine, homatropine, hyoscine, pilocarpine and physostigmine (which requires the addition of sodium metabisulphite, 0.05%).

Chlorhexidine cannot be used in strengths greater than one part per 10,000 with the phosphate buffer without

precipitation. Where phosphate is not necessary, or is chemically unsuitable, a solution of chlorhexidine diacetate containing one part per 20,000 in fresh and pyrogen-free distilled water has been adopted. These two vehicles are designed to replace the first six aqueous ophthalmic vehicles of the Australian Pharmaceutical Formulary.

Some commonly used drugs were found to require individual formulas.

Sulphacetamide Drops.—Sulphacetamide drops may be prepared as follows: sulphacetamide sodium, 10% or 30%; boric acid, 1% or 3%; chlorhexidine diacetate, 1 in 20,000; distilled water (fresh and pyrogen-free), to 100%.

Boric Acid, Adrenaline and Zinc Drops.—Boric acid, adrenaline and zinc drops are prepared as follows: boric acid, 3%; solution of adrenaline (1:1000), 12.5%; zinc sulphate, 0.25%; sodium metabisulphite, 0.05%; chlorhexidine diacetate, 1 in 20,000; distilled water (fresh and pyrogen-free), to 100%.

Carbachol Drops.—Carbachol drops are prepared thus: carbachol, 0.8%; sodium chloride, 0.25%; chlorhexidine diacetate, 1 in 20,000; distilled water (fresh and pyrogen-free), to 100%.

"Lachesine" Drops.—"Lachesine" drops are prepared thus: "Lachesine" chloride, 1%; sodium chloride, 0.9%; chlorhexidine diacetate, 1 in 20,000; distilled water (fresh and pyrogen-free), to 100%.

Fluorescein Sodium.—Lowe (1954) suggests the use of a 0.02% solution of thiomersal ("Merthiolate"), but this loses colour when heated in an autoclave. Topley and Wilson (1946) point out that all mercuric salts are ineffective as antiseptics. We have found no drug compatible with fluorescein that will prevent the growth of introduced bacteria, and are at present using an ineffective aqueous solution of 0.004% phenyl mercuric nitrate.

Amethocaine ("Decain").—Experience has shown that the best vehicle for amethocaine is a 2% solution of boric acid (with a pH of 6) in 1 in 20,000 chlorhexidine solution.

Sterilization of Eye Drops.

The method of sterilizing eye drops which was adopted was similar to that indicated in the British Pharmacopoeia or British Pharmaceutical Codex for multi-dose injections. Adrenaline, boric acid, brilliant green, carbachol, fluorescein sodium, methyl cellulose, silver nitrate and zinc sulphate are all autoclaved at 115° C. for 30 minutes. Amethocaine hydrochloride, physostigmine sulphate, pilocarpine nitrate and salts of atropine, homatropine and hyoscine are steamed at 98° to 100° C. for 30 minutes. Castor oil for oily drops is heated at 150° C. for one hour, and the drops are prepared aseptically in pre-sterilized containers.

Method of Issue of Eye Drops to Wards.

Five-millilitre screw-capped "Bijou" bottles containing these drops are sent to the wards, where there are sufficient droppers for each treatment. These bottles allow approximately five instillations per millilitre. This method of issue, in which a small volume only is provided, minimizes hoarding, with the consequent likelihood of contamination of the unused portions.

Eye drops for the wards are dispensed in five-millilitre bottles and screw caps are attached. A special heat-resistant "Cellophane" dust cap is placed over the metal caps, and the assembled bottles are then sterilized. Labels on each rack indicate the date of sterilization. These enable the dispensers to discard any bottles of drops which may have become inactive prior to their issue to the wards. Labels on the individual bottles provide a space on which the ward staff is instructed to write the date of opening. These bottles are discarded, even if not empty, one week later. As a complete range of sterile eye drops already dispensed is maintained in stock, the urgent preparation of drops seldom proves necessary.

Atropine drops and those of similar alkaloids are prepared at frequent intervals to avoid possible deterioration.

Fluorescein eye drops are issued in half-filled five-millilitre bottles after having been autoclaved. A very small volume is provided here because no efficient bacteriostatic is included.

Method of Issue of Eye Drops to Out-Patients.

Out-patients still receive a conventional dropper bottle, as it is unrealistic to expect a patient to boil a dropper for each treatment at home. Solutions cannot be sterilized in dropper bottles because, if the tops are screwed down tightly, the bulbs burst during the heating process, and if they are loose, evaporation or dilution may occur. Therefore empty bottles with loosened dropper tops are wrapped in special "Cellophane" and then autoclaved. Eye-drop solutions are prepared separately and sterilized in bulk (up to 500 ml.) before being inserted into the now sterile dropper bottles in an aseptic dispensing cabinet.

Sterility Tests on Eyedrops.

The virtually empty bottles discarded after use in the ward and out-patient department are sent to the medical bacteriologist, who cultures all bottles containing fluorescein and a selection of the remainder. Approximately 1000 such bottles have by now been tested and all have been proved sterile.

Sterilization of Dressings.

No eyes have been lost at this hospital from infection after lens extraction since Case IX listed in Table III. This patient was an edentulous man, aged 87 years. Intra-capsular lens extraction was attempted, but the capsule broke on delivery. Pyrexia and chemosis occurred on the second post-operative day. Pus taken from the conjunctival sac two days later was cultured and produced a heavy growth of a coagulase-positive staphylococcus.

Because of the resistance of the infecting staphylococcus to a number of antibiotics, it seemed logical to assume that the organism had originated within the hospital. Its source was strenuously sought. The drops used in the operating theatre and in the ward were proved sterile. All the surgeons visiting the department, together with the resident medical and nursing staff, had their noses swabbed and the organisms were cultured. Eleven coagulase-positive staphylococci were isolated, but in no instance was the phage type identical with that of the organism infecting the patient.

As no lead was given by these investigations, our thoughts turned elsewhere. A drum of dressings that had been "sterilized" as usual in an autoclave by the hospital's main theatre staff was taken to the medical bacteriologist for checking. He reported as follows:

Examination of Dressing Drum: A metal dressing drum was received with a request that its contents be examined for sterility. The drum was twelve inches in depth, with a movable central band containing a double row of holes for air displacement. A dead space of five inches existed on either side of each row of holes. This drum showed all the defects outlined in a memorandum to the medical superintendent seven months ago. Samples of the contents were removed and cultured for eighteen hours in nutrient broth with the following results.

The bacteriologist's findings were as follows.

From a double eye bandage and from gauze tampons in the lower layer of the drum, growths of coagulase-negative staphylococci were obtained. From towels in the middle layer, no growth was obtained. From gauze tampons and from a double eye bandage in the upper layer were obtained growths of a coliform bacillus, an aerobic spore-bearer and a coagulase-negative staphylococcus.

The bacteriologist concluded:

The contents of the drum contained many unsterile articles. The faulty design of the drum, which impedes air-displacement, is probably the most important factor involved. In addition, the double eye bandages were rolled into tight bundles, which would have prevented steam penetration, and the gauze tampons could have been packed less tightly also.

The drum used in the bacteriologist's test was similar to that, or more probably the actual one, in which the sheets, tampons, etc., used during this patient's lens extraction were autoclaved. Although it has not been proved that the ocular infection resulted from unsterile theatre dressings, it is suggested by these results.

As a result of the medical bacteriologist's recommendations, the theatre linen is now supplied with the large objects wrapped in cloth bundles and the smaller ones in paper bags, while the contents are packed more loosely. Sterility tests on these have given satisfactory results.

This investigation showed that the central sterilizing department of this hospital was not functioning properly. I should like to stress how important it is that surgeons take an active interest in the methods of sterilization and the manner in which they are carried out. It is a regrettable fact that autoclaves are among the most neglected and ill-understood pieces of hospital equipment. People who operate them should be permanent, well-paid workers whose sole task is the sterilization of hospital material. They should be adequately instructed by a medical bacteriologist, for a scant knowledge of steam engineering is not a qualification for this type of work. Autoclaves require frequent testing, and each load should include some form of visual indicator which will show that a sterilizing temperature has been reached. Although these indicators are not as reliable as tests carried out with spore envelopes, they will certainly detect any gross breakdown in the sterilizing cycle, and they have the advantage of providing immediate visual information about each load. When one considers the importance of steam sterilization, particularly in a country where tetanus is relatively common, it is beyond comprehension why its management is so often left in the hands of unskilled personnel with little or no understanding of the mechanisms involved.

Anderson (1958), having inspected many hospital autoclaves both in Australia and in England, states that it has been his experience that only a small percentage are even found to be working efficiently, and an operator with even the most elementary knowledge of steam autoclaving is the exception rather than the rule.

Inspection of Casualty Department.

As a result of seven simultaneous cases of meningitis following spinal anaesthesia in one hospital where imperfectly sterilized syringes were used, Pulvertaft (1949) insists that a central syringe service is essential. The best method is dry heat. As an alternative boiling may be employed, but chemical sterilization should never be used, as sooner or later this procedure breaks down.

At the public hospital to which I am attached, eye casualties are treated initially at the main casualty department. As the results of such treatment are sometimes deplorable, an inspection was recently made of this department. There was an insufficient supply of eye droppers and sterile towels. In addition, the failure of one autoclave to function made asepsis difficult to achieve. It was noted that the 70% alcohol solution was used for sterilizing both syringes and corneal foreign body needles. The formula for this solution is as follows: "Hibitane", 0.05%; cetrimide, 0.50%; sodium nitrite, 0.75%; alcohol, 70.00%; colour with "Edicol Supa Rosa", 1:40,000 (Rowe's colour index no. 749).

Before use, these instruments were washed in high-quality, but unsafe, tap water. The medical bacteriologist states that such a method invites infection with *Ps. pyocyanus*. (Incidentally, some 11 years ago in the course of about two weeks three patients suffered permanent visual loss from such infection after treatment for corneal foreign bodies in the casualty department.) As a result of these findings syringes are now sterilized in this hospital by dry heat. Sterilization of the foreign-body needles is achieved either by dry heat or by immersion in the hand-sterilizing solution. After the chemical method has been employed, they are washed in sterile water before use.

On investigation of the source of the unsafe tap water mentioned above, it was found that not only was the

so-called sterile water for the main theatres of this 800-bed hospital provided by an unsound method, but even this method was not properly carried out. Moreover, it was performed by an untrained person without any supervision. Finally, the sterility of the water and the purposes for which it was used were not periodically checked.

Other Factors Affecting Sepsis in Ophthalmology. Pre-Operative Administration of Antiseptic Eye Drops.

In view of Fine and Zimmerman's (1959) account of intraocular fungous infection following surgery, it would appear unwise to use antibiotics such as "Terramycin" before a lens extraction. However, despite the apparent efficacy of tears, it seems wise to use an antiseptic drop for a few days before operation. Chlorhexidine is an efficient bacteriostatic and is also effective against some species of fungi. Consequently, I have recently been using a sterile aqueous solution containing chlorhexidine (0.05%) and boric acid (2.0%). I have also incorporated methyl cellulose in a concentration of 0.5% to increase the viscosity, and possibly the time of exposure of the contents of the conjunctival sac to the antiseptic.

Preparation of the Patient.

An important aspect of preparation of the patient is illustrated by the following story:

About ten years ago I was asked by a colleague to see an elderly man on whom he had performed a lens extraction. Subsequently the patient developed panophthalmitis, and the eye was eviscerated. He had foul teeth. A year later the lens of his other eye was extracted, with an identical result. My colleague had not insisted that the patient's dental infection should be eliminated before the second operation.

Hobson and Juel-Jensen (1956) demonstrated conclusively that patients with subacute bacterial endocarditis caused by *Streptococcus viridans* have the primary focus of infection in their teeth and dental sockets. The infrequency of this type of endocarditis in the edentulous has been confirmed by Dormer (1958). I believe strongly that a lens extraction should not be undertaken in the presence of dental sepsis. The abolition of sepsis does not necessarily entail the wholesale removal of teeth, but the patient should see a dentist and have his mouth made reasonably clean.

I do not operate on a diabetic patient unless the fasting blood sugar level is below 140 mg. per 100 ml. A physician, preferably one who is interested in this disease, treats the patient during a pre-operative week in hospital, and maintains the post-operative stabilization as well. Sometimes stabilization to this standard has taken eight weeks, even in a treated diabetic previously thought to be receiving an adequate maintenance dose of insulin.

None of my patients has had eye swabs cultured before operation. The decision to operate is made by clinical judgement, as my experience indicates that such cultures serve no useful purpose, confirming the opinion, expressed by Mann (1949) 11 years ago, that "it therefore appears that clinical judgement is certainly as safe as, and possibly a little safer than, culturing".

Personal examination of all private patients, with the object of detecting conjunctivitis or other evidence of local infection, is carried out on the day before operation. In public hospitals I rely on the judgement of resident medical and nursing staff. Operations which have been postponed on account of such local infection have been extremely rare. I have never syringed a tear sac pre-operatively in a search for infection unless there has been a history of, or clinical signs of, dacryocystitis.

When the patient is in the operating theatre, the skin in the region of the eye should be wiped with the hand-sterilizing solution of which the formula was given earlier. The eye should be thoroughly cleansed with an antiseptic, preferably the 1 in 2000 chlorhexidine solution, as at the present time there is nothing better.

Sterilization of Instruments.

Dry heat is the method of choice for the sterilization of instruments.

Cap and Mask.

An operating cap must always be worn and a suitably designed mask is essential. It protects the patient from the surgeon by covering the two important sources of infection, the mouth and the nose. The present high percentage of nasal carriers of staphylococci amongst hospital staff makes the covering of the nose at least as important as the covering of the mouth—probably more so. The face mask is designed to filter air passing through it and to trap droplets expelled during speaking. The use of impermeable material such as "Cellophane" is not wise, since it deflects air out of the side of the mask, and the end result is the same as if no mask at all had been worn. The capacity of the mask to trap droplets is strictly limited and it should not be exhausted by unnecessary talking. Stevenson and Reid (1941) have said: "Talking through a mask over an open wound is bad enough when the subject pertains to the patient, but to do it for entertainment is sheer malpractice."

Dr. K. F. Anderson, in a personal communication (1960), states that one mask, which on being tested was found to trap all the bacteria from a known nasal carrier, is made by the firm of Johnson and Johnson. It is of simple cotton gauze in two layers, each of a different ply. These masks should be sterilized by boiling for 15 minutes.

Scrubbing Up.

Hand-washing is of particular importance, as many ophthalmic surgeons prefer to operate without gloves.

I handle all sutures and needles with my ungloved fingers, accepting the risk of contamination. In consequence, much trauma to fine Grieshaber needles is avoided, and the tissues can be manipulated more gently. I take care never to touch the patient's skin with my fingers at any stage of the operation.

Any spores on the hands are likely to be superficial and readily removed by any means. The transient organisms are easily eliminated by routine scrubbing procedures when soap and running water are used, but the resident flora is virtually impossible to eradicate. With this in mind, it is wise to follow the routine soap-and-water scrub with immersion in the hand-sterilizing solution which is the same as that described for syringes and foreign-body needles.

Wetting the hands for two to three minutes in this solution will kill any remaining vegetative bacteria. Under optimum conditions, all such organisms would be killed within 15 seconds. This immersion should be repeated at intervals if the operation is a lengthy one. The addition of chlorhexidine to the alcohol leaves the skin with some residual bactericidal properties, whereas the action of alcohol ceases as soon as it has evaporated. Ungloved hands should be repeatedly scrutinized to exclude minor sepsis, which is almost invariably staphylococcal, and which can have serious consequences if ignored. Inflammatory lesions, however small, should be an absolute contraindication to further operative work.

Operative Technique.

Clumsy or careless surgery no doubt accounts for some infected eyes, although this is difficult to prove.

I firmly believe that the eyelids of the patient cannot be regarded as sterile. Every care must be taken, therefore, to see that the Graefe knife does not rub across the stump of a lash. Corneal sutures should not be allowed to glide along the lid margin. Probably all of us have seen an iris repositor touch the skin before entering the anterior chamber. This must be one of the most potent causes of infection. The old adage that an instrument should enter the eye only once is, to my mind, misleading. Surely what is meant is that an instrument must never become contaminated before entering the eye.

It is said that slow surgery increases the risk of infection, but I have seen no figures to substantiate this.

Apart from local treatment, less than 3% of my patients have been given sulphonamides or antibiotics post-operatively, and I suspect that even then they were usually unnecessary.

Post-Operative Dressings.

After observing the way dressings are sometimes done, one is led to the opinion that ophthalmologists should dress their patients' operation wounds themselves. There can be no question that the patients suffer damage less frequently than if these dressings are done by less skilled persons. Professor Pauque has the reputation of being one of the best ophthalmic surgeons in the world. When in Lyons five years ago, I noted that he found time to do his own dressings.

Discussion.

It is suggested that at the time of every post-operative evisceration we should engage the active assistance of a bacteriologist in an endeavour to culture the causative organism.

I have been distressed to find so much at fault in the hospital with which I am associated. It seems apparent, as a result of the discussions arising from my previous papers, that conditions in some hospitals in other cities are similar or even worse. It behoves all of us, therefore, to inculcate into the officers responsible for the administration of our hospitals the relevant principles enumerated here. Furthermore, there is an imperative need for medical officers, aided by the expert knowledge of the medical bacteriologist, to conduct regular routine inspections of all the methods used throughout their hospitals. Particular attention must be paid to operating theatre techniques, nursing traditions, dispensing methods and hospital supplies. Where necessary an up-to-date revision of the systems practised must be instituted.

Summary.

The incidence of serious post-operative infection after various ocular operations performed in Adelaide is reviewed.

In a series of 1411 operations performed by me during the years from 1949 to 1960, there were no instances of infection causing loss of sight.

Analysis of a series of 1321 lens extractions performed by 23 ophthalmologists at a public hospital during a similar period showed that there were nine cases of post-operative panophthalmitis, eight necessitating evisceration and one enucleation.

The cause of 79 cases of panophthalmitis found among 344 consecutive cases of evisceration or enucleation at a public hospital during a ten-year period is reviewed. Thirty were due to early or late post-operative infection.

In one case, in which a corneal ulcer was iodinized, the subsequent instillation of infected cocaine drops led to total loss of vision.

Bacteriological investigation at an 800 bed public hospital disclosed defects in asepsis caused by weaknesses in both nursing practice and dispensing methods which led to contamination by microorganisms of sterilizing fluids and eye drops throughout the ophthalmic department. Cultures prepared from a series of 63 bottles containing eye drops revealed 13 instances of gross contamination, in 12 of which *Ps. pyocyanus* was incriminated, and in one *Staph. aureus*.

An inspection of the casualty department disclosed many defects in asepsis, such as the ineffective sterilization of syringes and corneal foreign-body needles.

A brief scrutiny of the main operating theatre block revealed the incorrect use of high-quality tap water as sterile water.

In one case of panophthalmitis following lens extraction, it is suggested that unsterile theatre dressings were the cause.

Other points in the prevention of sepsis are stressed, including the correct sterilization of instruments, dressings and scrubbing brushes.

A full description is presented of the preparation, sterilization, method of issue, manner of use and sterility testing of eye drops.

The necessity for an efficient operating mask, the desirability of the pre-operative administration of anti-septic eye drops, the importance of the preparation of the patient and the principles of scrubbing up are discussed.

Comments on operative technique and post-operative dressing conclude this paper.

Acknowledgement.

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MANAGEMENT OF THE AGED PATIENT.¹

By J. G. RADFORD, M.B., B.S., M.R.A.C.P.,
 Sydney.

... The sixth age shifts
 Into the lean and slipper'd pantaloon,
 With spectacles on nose and pouch on side,
 His youthful hose well sav'd, a world too wide
 For his shrunk shank; and his big manly voice,
 Turning again towards childish treble, pipes
 And whistles in his sound. Last scene of all,
 That ends this strange eventful history,
 Is second childishness and mere oblivion,
 Sans teeth, sans eyes, sans taste, sans everything.

—Shakespeare, *As You Like It*, 2: VII.

¹ Read at a meeting of the New South Wales Branch of the British Medical Association on August 18, 1960.

BECAUSE of the magnitude of this subject, my considerations will be limited to three aspects. First, I shall attempt to make an assessment of the situation involved, particularly as regards the volume and scope of the job to be done. Secondly, I shall consider in some detail the general management of the aged patient with the accent on the sociological aspects. Thirdly, I shall refer briefly to some of the more common aspects of clinical medicine encountered in dealing with these patients.

ASSESSMENT OF THE SITUATION.

Definitions.

At the outset I shall define two terms so that we may clearly understand the terms of reference of this paper.

"Aged." It is not easy to define mathematically the word "aged". Legally, the pensionable age is 60 years in the cases of females and 65 in males. Many would agree that such a definition of "aged" is absurd. The Hospitals Commission regards the members of its boards as becoming aged at 70 years. Obviously no fine line of demarcation can be drawn as to when one becomes aged. The process of aging is, as we all know, a gradual one. I shall use the word "aged" in the sense that one is physically or mentally incapable of contributing usefully to the common good, or is likely to be requiring supportive help of some description.

I shall refer to two broad groups defined by Sheldon (1960) in a paper presented to the annual meeting of the British Medical Association in Edinburgh, in 1959—namely, that of early old age, from 60 years to the mid-seventies, and advanced old age as that past the mid-seventies. This classification is a useful working one, because, as was pointed out by Sheldon, the problems involved in these two groups are somewhat different.

"Patient." To define the word "patient" in this context is perhaps even more difficult. Sometimes one can barely draw a distinction between physiological aging and the onset of pathological processes. I am not qualified to discuss the genetics, biochemistry or histology of normal aging. There are some who would argue that just as teething produces nothing but teeth, so aging produces nothing but age. One could quote the case of "health" described by that delightful writer, Richard Asher (1958), in a female, aged 90 years. On the other hand, one more commonly finds the insidious onset of a multiplicity of pathological changes, some minor, some major, the sum total of which render the subject in need of supportive care. I shall therefore use the word "patient" to connote one whose condition requires care by his doctor or by ancillary services.

Extent of the Problem.

In Australia at present there are 513,789 old-age pensioners—that is, approximately 5% of the population. This does not include persons of pensionable age who are ineligible for the pension. It is well recognized that the proportion of elderly people in the population is steadily increasing. I shall not attempt to analyse the various possible explanations of this—for example, a declining birth rate in previous years, survival from diseases which previously extracted their toll in youth and middle age, etc. I would, however, again quote Sheldon, who remarked that whereas it takes 70 years to grow an old person, it takes only 20 years to grow someone capable of caring for him.

It is interesting to analyse in further detail the age-sex structure of this aged population. Table I shows the analysis of persons in the various quinquennia, from 60 to 64 years and so on, in each of the sexes in old-age pensioners in New South Wales in 1958. The femininity of the problem is at once apparent, there being over double the number of females in comparison with males in this group. Another point is that 33.8% are in the advanced old-age group—that is, beyond the middle seventies.

Unfortunately, it is not possible to ascertain exactly how many of these old people require medical care, but it is

reasonable to assume that very many in the early old-age group require occasional care, and probably most of those in late old age require a considerable amount. Obviously, nearly all need the help of sound preventive medicine.

One might ask, by whom is the professional medical care of these people provided? A few are permanently resident in State institutions, but the majority receive their attention in their own homes or at privately owned institutions from their family doctors. It is therefore the general practitioner who is most concerned with the practical aspect of this problem. We have not in this country reached the stage at which the specialist geriatrician is called upon to treat these people. Even if this specialist did exist, his place would be purely in institutional or consultant practice. The properly trained family doctor should be perfectly competent to deal with these patients. He should be taught the aspects of preventive medicine, social medicine, sound clinical diagnosis and practical (and practicable) therapeutics in his undergraduate training. He should receive further training and practical experience in his immediate post-graduate years if he is electing to enter general practice. The volume of work devolving on an individual practitioner will vary. In a solo practice town, the volume will be determined by the percentage of these people in the population. In ordinary practice, where each doctor may have a particular bent, perhaps to paediatrics or to gynaecology, or perhaps to general medicine, the proportion will vary. I have recently, as part of some morbidity studies being carried out by the Australian College of General Practitioners, had occasion to analyse the age-sex structure of patients consulting me. My findings are presented in Table II, which shows the percentage of patients in each decade consulting me in the first six months of 1960. These figures are determined only on the fact of one or more consultations occurring, and not on the volume of work required for each patient. For purposes of comparison I have shown the population distribution of the last census in the last column. This type of practice obviously has a bias towards "geriatrics", partly because of personal interest, and partly because it is in a suburb where the population tends to be aged. I have no census figures to support this, but it is known that because of the many residential in this area, young married couples on the arrival of a family migrate into the newer suburbs. It is on my practical experiences with these patients that my own observations are made.

Scope of Attention Required.

The degree of incapacity of these aged patients and the amount of attention required vary, although they do increase with advancing years. These people may be divided into the following three broad categories. (i) Those physically able to care for themselves and, if they desire, to earn sufficient to contribute to their maintenance. However, many of these are dependent on the State. Social and preventive medicine may be required here, but little active therapeutics. (ii) Those with physical limitations necessitating supportive care. The intellectual vigour of many of these is still present, and they desire to remain useful citizens. The supportive care may be provided by relatives with whom they live, or by institutions. Many of them fall into Sheldon's group of "early aged". These are also the aged of the "lean and slipper'd pantaloons". Appropriate care may retain these people in this group for many years before they enter the next group. (iii) Those who need some form of continuous medical supervision. If they are at home, this will require the presence of a relative or nursing aid or good neighbour most of the time. Most of these fall into Sheldon's category of "advanced old age". Some of them are continuously bed-ridden and fall into Shakespeare's seventh stage.

GENERAL MANAGEMENT OF THE AGED PATIENT.

Social Considerations.

This aspect of the subject requires attention more to social medicine than to pure clinical medicine. The first questions we may ask are where and by whom this management will be provided.

TABLE I.
Age and Sex of Old-Age Pensioners, N.S.W., 1958.

Sex.	Numbers.	Age Group (Years): Percentage in Each.				
		60-64.	65-69.	70-74.	75-79.	80 and Over.
Males	66,993	—	8.3	10.7	7.2	5.1
Females	144,667	11.9	17.9	17.4	11.9	9.6
Total	211,660	11.9	26.2	28.1	19.1	14.7

The Family Home.

Ideally, I believe, the aged patient should be managed in his own home. If the aged relative is to be sociologically part of the family, clan or tribe, it is highly desirable that at the onset of a certain age or advent of a pathological process he should not be outcast into the care of the State or an institution if this can be avoided. The provision of adequate care in the twilight of one's days is the birthright of any individual, be this in his own or in his relatives' home or an institution. Most would prefer it in their own homes. Criticism has been levelled at the young and middle generations of today that they are omitting to provide this care for the older generation. A lot of this criticism is unjustified, for there are various cogent reasons why it is not always possible for them to be provided with this care at home. One of the most valid reasons is the lack of living space in a modern dwelling. This is partly due to the cost of building. However, lack of finance alone is rarely the only reason for failing to keep the aged at home. The provision of a pension largely overcomes this, and it is actually more expensive to support the aged in an institution than in one's own home. Another reason advanced is that the young generation should not have to be saddled with the frustrations of caring for their old. This is not insurmountable with a reasonable amount of "give and take" on both sides. However, so many married women are, sometimes of necessity, gainfully employed at breadwinning that they are just not at home to provide daytime care for their elderly relatives, and ought not to be exhausted by the occasional nocturnal care which may be necessary.

Their Own Lodgings.

Many elderly persons, with or without relatives, prefer to be independent and provide their own lodgings while they are able to care for themselves. Sometimes the assistance of good neighbours enables such to be achieved. Additional help is the provision of such services as "meals on wheels". This meal service and the use of visiting social workers is sadly lacking in this country. Religious and State visiting nursing services are a great help, but could be increased manyfold. These aids make it possible for aged persons to live on their own and manage, when otherwise they might not be able to do so. If they are able to get to social centres and to occupy themselves, life will not be so lonely for them. Organized visits by their own contemporaries also serve to boost morale. This can sometimes be accomplished through the local senior citizens' club.

Institutional Care.

Sometimes institutional care becomes a necessity. At present, in this State the provision of such homes is largely a matter of private enterprise. The few State homes have long waiting lists. Villages for the elderly and such like are unfortunately few in number. In Worcester, a city of some 63,500 inhabitants, there are a number of almshouses endowed over the centuries for the care of the aged poor. Here they may lead a semi-independent life in small flats, with their own allowance of coal for the winter and other amenities. Private institutions in Sydney are numerous, but are far from cheap, and the attention available is not always what might be desired, although by and large it is reasonably good. Many old people are very happy in these

institutions, particularly if they are of the gregarious type and get along well with those of their own vintage. On the other hand, many find it hard to adapt themselves to this form of institutional life, particularly if the type of surroundings is foreign to them. This undesirable aspect of the problem was recently stressed by Gibson (1960), an English practitioner, after a visit to the superficially excellent Old People's Town in Copenhagen. He was disappointed at the soul-destroying potentialities of institutional life.

TABLE II.
Analysis of Patients having Consultations: Sex and Age Groups* (Percentage).

Decade.	Males.	Females.	Total.	Population.
0-9	8.0	5.7	6.8	20
10-19	4.3	6.7	5.5	16
20-29	7.5	7.6	7.6	13
30-39	10.8	13.8	16.6	15
40-49	14.4	7.6	10.8	13
50-59	15.5	11.0	13.1	10
60-69	13.9	19.1	16.6	7
70-79	14.4	18.1	16.4	1
80 and over	2.1	10.5	6.5	6

Role of the Doctor. Pensioner Medical Service.

The pensioner medical service is one of the greatest contributions which the Government has made to social medicine in this century. Abuses such as over-visiting have been estimated at 5%. I prefer to look at the remaining 95% of practitioners who are trying to render an honest service. I suspect that perhaps 10% are not rendering sufficient service. Perhaps more could and would render this service better if they understood more fully the problems involved.

Assessment of Social Situation.

Proper provision of this service needs awareness of the problem, which I hope I have illustrated sufficiently. It needs preparedness to cope, which only the individual conscience can provide. It needs ability to deal with the patient and his physical status, together with his family and social surroundings. The family doctor is in an ideal position to do this. Training should enable him to make a correct clinical assessment of the patient. He must be able to recognize symptoms and signs of overt pathological change. He must learn to predict in which direction further pathological changes are likely to take place and to attempt to forestall them. For example, in vascular disease, if this presents with cerebral insufficiency, coronary changes must be watched for and vice versa, and peripheral vascular changes may require attention also.

The family doctor will be aware of the financial and emotional status of the patient's children (now middle-aged) and grandchildren (as likely as not in the young or adolescent stage). He can assess how much they are able to take. He knows when the geriatric member of the family may have to be put in an institution in the interests of the welfare of the rest. He can help the family to adapt themselves to the presence of a geriatric patient in their midst, and can teach them the role which they can play in

TABLE III.
Analysis of Presenting Illnesses in 189 Aged Patients, January 1 to July 31, 1960.

Disease.	Age 60 to 74 Years.			Age 75 Years and Over.			Age 60 Years and Over.		
	Males. (48)	Females. (73)	Total. (121)	Males. (21)	Females. (47)	Total. (68)	Males. 69	Females. 120	Total. 189
Infections	1	1	2	—	—	—	1	1	2
Neoplasms	2	7	9	3	2	5	5	9	14 (6 benign)
Allergic Thyroid	—	7	7	—	—	—	—	7	7
Diabetes	2	1	3	2	5	7	4	6	10 (9 subthyroid)
Blood	—	4	4	—	—	—	—	4	4 (3 pernicious anemia, 1 purpura)
Psychiatric	4	13	17	—	4	4	4	17	21 (3 psychoses)
Central nervous system	5	4	9	8	8	16	13	12	25 (21 vascular)
Eye and ear	2	4	6	2	4	6	4	8	12
Circulatory : Arteriosclerotic	15	7	22	10	9	19	25	16	41
Hypertensive	4	11	15	2	22	24	6	33	39
Valvular, functional, arteries, and veins	7	11	18	5	—	5	12	11	(6 aortic stenosis 2 paroxysmal auricular tachycardia, 1 polyarteritis)
Respiratory : Upper respiratory tract infection	5	6	11	1	5	6	6	11	17
Pneumonia and other	7	3	10	5	2	7	12	5	17 (2 bronchiectasis)
Digestive : (Esophagus, stomach, duodenum and gall-bladder	4	4	8	1	3	4	5	7	12 (2 gall-bladder)
Intestines and hernia	3	(1 gall-bladder) 6	9	1	(1 gall-bladder) 7	8	4	13	17 (3 hernias)
(2 hernias)	—	—	—	—	—	—	—	—	—
Genito-urinary : Renal	3	1	4	—	—	—	3	1	4
Genital	2	3	5	—	4	4	2	7	9
Skin : Infective	2	4	6	1	1	2	3	5	8
Other	6	6	12	1	2	3	7	8	15
Skeletal	10 (1 gout)	18	28	3	14	17	13	32	45 (1 gout)
Symptoms, etc.	5	5	10	3	3	6	8	8	16
Injuries : Fractures	2	6	8	—	5	5	2	11	13
Other	2	4	6	1	4	5	3	8	11
Total Illnesses	—	—	—	—	—	—	—	—	393

helping such a person. He may well explain to the others the psychological outlook of the old person. They may then be better able to cope with some of the intolerance and petulance which afflict a few of these older patients.

General Physical Care.

Diet.—With regard to diet, the doctor realizes that adequate caloric intake is necessary, and also that sufficient protein and vitamins must be included. The isolated aged patients who cannot be bothered cooking for themselves properly must be taught to do so. Vitamin supplements may occasionally be required. Also, the patient's relatives sometimes need to learn that it is not necessary to overfeed the old people, and that there is no need to be anxious if grandmother refuses to eat a three-course dinner immediately before going to bed.

Activities.—With regard to activities, the patient should be encouraged to feel that his presence is appreciated, and he should be given tasks which satisfy him that he can still play a useful part and that he is not merely an unwanted burden. Outings by relatives should be encouraged.

Clothing.—Adequate warm clothing and heating in winter should be available, and also cool drinks and fans or other cooling devices in the summer are required. I

need hardly remind you that the very old, like the very young, have highly sensitive heat-regulating centres.

Sleep.—The sleep rhythm in the elderly is often of the "early to bed, early to rise" variety, and relatives must be taught to tolerate this habit.

Luxuries.—Provision of a television set these days is probably hardly regarded as a luxury. This diversion is extremely valuable for the elderly who still maintain an active interest in what is going on in the world outside, from which they may be barred by virtue of some disability. On the more luxurious side, do not forget the psychological uplift created by a new hat for grandmother, be it the latest fashion creation or something worthy of that famous old lady, Queen Mary.

CLINICAL MEDICAL ASPECTS.

I have considered at some length the social and preventive medical aspects in the management of the aged patient. The purely clinical problems of geriatrics should be familiar to anyone adequately trained in clinical medicine. Some diseases are peculiar to the older age groups—for example, osteoarthritis, senile deafness, cataracts, etc.; others occur at all ages; some which are more common in youth turn up in an atypical form in older age—for example, acute appendicitis—and may be a challenge to one's diagnostic acumen.

Frequency of Various Diseases in the Aged.

I have analysed the conditions which I have seen in the first seven months of this year in my own patients, and the findings are summarized in Table III. The persons involved are divided into two groups, those 60 to 74 years of age and those of 75 years or more, corresponding to Sheldon's classification. There are 121 in the former group and 68 in the latter. The sex distribution shows a highly feminine trend. The diseases named represent conditions for which advice was actually sought, and not the number of services rendered for any particular condition. The classification is that of the World Health Organization, with some condensation in the interests of simplicity. It is interesting to note the frequency with which various conditions occurred. Circulatory conditions head the field by a great distance with some 80 instances of arteriosclerotic and hypertensive disease. Next in the list come skeletal diseases with 45 instances, most of which were due to osteoarthritis of a sufficient degree to require relief of symptoms. The next group numerically is that of respiratory disease with 34 instances; but this includes a number of acute upper respiratory infections, and only 15 patients suffered from pneumonia. Digestive system disorders accounted for 29 cases, which are a mixed collection, including a few patients with peptic ulcers, several patients with symptomatic diverticulitis, three old men with herniae and two old women with symptoms of gall-bladder disease. Amongst the psychiatric group are 21 patients, of whom only three were frankly psychotic. Fifteen patients presented with various types of skin disease other than staphylococcal infections. Ten patients had diabetes mellitus and nine women evidence of hypothyroidism. Eight malignant tumours appear in the series. One of the problems in dealing with these patients is the presence of a multiplicity of diseases, and this table shows that over half the patients had at least two distinct conditions.

It is impossible to cover the special points in the management of all these conditions of the aged in any great detail, but I shall quote three cases to illustrate some of the problems involved.

CASE I.—This patient is a man, now aged 65 years. At the age of 59 years he presented himself with mild hypertension and symptoms of coronary insufficiency. At the age of 60 years he had a myocardial infarction. After a gradual recovery, he was well until onset of a cerebral thrombosis with hemiplegia at the age of 61 years, which still largely incapacitates him. He has peripheral vascular disease, and has struggled through two winters with circulation to the toes of doubtful integrity. All this is the purely clinical side. One might well ask what would be the place of continuous anticoagulant therapy for purposes of prevention in this patient. Initially his coronary occlusion was so treated. At that time continuous anticoagulant therapy was not in use. At the time of his first cerebral thrombosis it was contraindicated. At this stage it might avert further damage, but its use is financially impracticable. Dietary fat restriction was so seriously practised by the patient himself that at one stage he resembled a patient with anorexia nervosa. His cardiac condition causes no trouble because he is so inactive. Prolonged physiotherapy has got him to the point where he is able to potter around the house with a quadriped walking stick, which I recommend as a useful aid in this type of case. It is much more stable than a cane. However, the psychological problem merits brief consideration. Always somewhat introspective, he has become increasingly so, and at times frankly depressed. As an old soldier he has become almost obsessional about his inability to get his vascular degeneration accepted as due to war service. At times, although he was previously a most attentive husband, "illness has made him so demanding that his wife, who has a very stable personality, has developed frank neurasthenia. Sympathetic but firm handling and suitable readjustment all round have ameliorated this situation somewhat. However, it still requires at least as much attention as his physical condition.

CASE II.—This female patient, now aged 88 years, came to a convalescent home at the age of 81 from a hospital with the diagnosis of pathological fracture of the neck of the femur, to die in a caliper. Clinical examination revealed no primary tumour, but the orthopaedic surgeon considered "pinning" contraindicated. It was decided to get her walking on her caliper. After many attempts to achieve this satis-

factorily, the caliper was finally abandoned, and now after a pseudarthrosis has developed she gets around quite adequately with a walking machine. Here let me stress the advantage of a machine with long, flat, pointed feet like skis, which enable the machine to be pushed along wooden floors and over mats without disaster. This woman has moderately severe hypertension, which has on occasion threatened her with pulmonary oedema and hypertensive encephalopathy with nocturnal fits. Anti-convulsants have relieved the latter symptomatically, and no attempt has been made to diagnose any other convulsive aetiological factor. Digitalis has averted further pulmonary oedema, and chlorothiazide has assisted the management of her hypertension and also the oedema of the legs. The latter, if in part cardiac, is at least largely due to bilateral femoral thrombosis. While hardly normal, she is very happy, and appears to be enjoying her later years.

CASE III.—A female patient, now aged 80 years, presented herself originally at the age of 76 with cerebral thrombosis. She fell out of bed and fractured an already osteoporotic spine. At the age of 77 she suffered a fractured neck of the femur, which the orthopaedic surgeons declined to pin. By dint of getting her into a chair, she has been kept alive, even if she has postural oedema of the ankles. Unfortunately her emotional lability associated with a cerebral thrombosis gives her some tearful moments. However, her sense of humour is also intensified and is a great stronghold to her, as well as to other patients and to their doctor, who has at times to put up with some saddening sights.

SUMMARY AND CONCLUSIONS.

I have endeavoured to outline the problems involved in the management of the aged patient. I would stress that, in dealing with this type of patient, while a proper clinical appraisal is obviously necessary, it is paramount to assess and manage the patient in his sociological conditions, and that the family doctor is the person who must do this. Because of population trends, more demand will exist for this type of work. I would make a plea for further education in the social and clinical implications of this work at both undergraduate and immediate post-graduate level.

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PULMONARY HYDATID DISEASE.

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ALTHOUGH there is much literature on hydatid disease, there has been no recent review of the long-term results of treatment in this country. This is a study of all admissions for proven hydatid disease of the thorax between June, 1945, and June, 1960, to the Royal Prince Alfred Hospital, Sydney. During this time 72 patients were admitted 116 times to this hospital because of hydatid disease. Of these, two patients had been operated on originally at another hospital, and five others had first been treated at this hospital before 1945. Therefore, 65 patients' first admissions will be analysed here; but the whole group of 72 patients will be studied as to their sex, age at onset, family history, residence in city or country, recurrences and follow-up findings.

In a recent survey, Gemmell (1957, 1958) found that 32.2% of dogs in the southern tablelands were infested with *Echinococcus granulosus*, and that 31.9% of sheep-

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livers contained hydatid cysts. In the south-western slopes of New South Wales, the figures were 23.7% and 17.7% respectively. Many of our patients have obtained their infections in these districts. Gemmell also found that the incidence of infested dogs was higher among homestead pets (31.6%) than in working sheep dogs (20.7%); although the number of pet dogs examined was small and the differences may not be statistically significant, yet this shows that pet dogs kept in homesteads are at least as great a menace from the point of view of hydatid infestation as are the working sheep dogs. He also found *E. granulosus* in two out of 52 dogs examined in Sydney suburbs.

Incidence.

Although hydatid disease has a world-wide distribution, the greatest incidence is in Australasia and in South America. The comparatively small number of cases which occurred in North America was reviewed by Phillips in 1930. The hydatid surveys by Gemmell referred to above (1957, 1958), compared with a similar survey by C. Ross in 1926, showed that in a period of 30 years there has been no reduction in the infestation rate in sheep and dogs in this country. As might have been expected from this, there has been no decrease in the number of new patients admitted to this hospital with pulmonary hydatid disease in the last 15 years (Table I).

TABLE I.
Admissions of New Patients.

Period.	Number of Patients.
June, 1945-1949	16
1950-1954	24
1955-1959	21
January to June, 1960	4

Age and Sex Distribution.

There is a nearly equal distribution of patients in all age groups with a peak in the 11 to 30 years age group (Figure I). The youngest patient in this series was aged six years and the oldest 70 years at their first presentation, but it must be realized that this review is from a hospital which is primarily for adults. Myers (1960) states that at the Royal Alexandra Hospital for Children in Sydney, 98 patients with hydatid disease (45 of these with pulmonary cysts) have been treated during the past 20 years, and at the Royal Children's Hospital in Melbourne 72 patients (41 with pulmonary cysts) have been admitted since 1938.

Contrary to most previously reported series (Waddle, 1950; Fairley, 1922) there is no striking male preponderance in our series, there being 39 male and 33 female patients.

Presence of Hydatid Cysts in Other Organs.

In 47 of these 65 patients, the hydatid cysts were confined to the lungs; in 11 the liver was also involved (one of these also had hydatid cysts in the vertebral column), three had cysts in the liver which had ruptured into the pleura and/or lung, one had cysts in the heart only (but had had cysts removed from the lung previously), and one had a single cyst in the heart at autopsy. One patient had a cerebral hydatid cyst (reported by R. A. Money in 1958) and another a cyst in the thigh.

Rural versus Urban Residence.

Of the 72 patients, 64 lived permanently outside the Sydney metropolitan area, four went to the country on their holidays and only two were never beyond Sydney; in two cases the place of residence was not recorded. This reaffirms that infection through dogs at city

abattoirs is of little significance, and that the disease is commonly acquired from infested country dogs. Only five patients in this series were not born in Australia, and only two of these are likely to have acquired their infection in another country.

Nine of the 72 patients (12.5%) gave a family history of hydatid disease, and in two of these cases, two members of the family were affected.

Mode of Presentation.

Pulmonary symptoms were the mode of presentation in 81% of cases, the most frequent cause being a pneumonic episode. Five patients were discovered on mass radiographic surveys, and five when radiologically examined for other reasons, including two with previously diagnosed hepatic hydatid disease. Six of these patients were symptomless, the other four having only minor pulmonary symptoms. It is interesting to note that only 14% of patients admitted to hospital with pulmonary hydatid disease after 1952, when routine mass radiography began, were discovered by this method. In two cases unsuspected hydatid cysts were found at autopsy.

Symptomatology.

As is seen in Table II, cough, sputum and pain in the chest, often due to superimposed infection, were the commonest symptoms. The expectoration of hydatid elements, often described by patients as "grapeskins or bits of plastic material", though of course diagnostic, occurred in only 20% of these cases.

Hæmoptysis, in amounts of greater than 3 oz., occurred in nine cases, while in 20 there were small amounts of blood in their sputum. Eight patients had blood in their sputum on one occasion only, while 21 had recurrent hæmoptyses.

Weight loss of over one stone occurred in 15% of cases, often from associated infection.

Anaphylactic or allergic reactions occurred in only five patients; two had definite attacks of wheezing (with urticaria in one), which disappeared after removal of the cyst; one had "fits" consisting of generalized itching, cold shivers, sweating, cyanosis followed by weakness and occasionally loss of consciousness; one patient had attacks of angioneurotic oedema; and one had a fatal anaphylactic reaction after rupture of a hydatid cyst into the right ventricle. However, Professor Harold Dew (1927) considered that these reactions are frequent.

The way in which these cysts presented pathologically is set out in the following tabulation:

Simple cyst of the lung	22 cases
Pneumonia	14 cases
Rupture into bronchus	9 cases
Hydatid lung abscess	5 cases
Pyopneumothorax	5 cases
Pleural effusion (due to rupture)	3 cases
Broncho-biliary fistula	2 cases
Broncho-pleuro-biliary fistula (with pleural effusion)	2 cases
Hydatid cysts of the heart	2 cases
Calcified hydatid cyst of the lung	1 case

It is interesting to note that in 26 cases the cysts had ruptured into either the bronchial tree or the pleural cavity, and one cyst of the heart had ruptured into the right ventricle.

Site of Cysts.

Whereas in most reported series (Dew, 1928; Officer-Brown, 1958) cysts were found much more frequently in the right lung, we have found only a slight right-sided preponderance (Table III). The lower lobes were involved more frequently than the upper. Three patients had two cysts, and three had more than two cysts, when first examined. All these patients had cysts in the right lung, but only three had cysts also in the left lung.

The Value of Laboratory Tests.

The Casoni test produced a positive result in 47% of the cases in which it was done (Table IV), and it was rare for the delayed reaction to be positive if the immediate reaction was negative.

The result of the hydatid complement fixation test was positive in 55% of cases in which it was performed. Of the patients who gave a negative result, two had positive Casoni reactions, and in one case the latter test was not performed. Of the patients with negative Casoni test results, six gave a positive response to the hydatid complement fixation tests, but in 12 cases the latter test was not performed.

22 hydatid complement fixation tests produced a positive result and in nine significant eosinophilia was present.

Diagnostic bronchoscopy was performed in 11 cases, and in nine of these congestion of the bronchial mucosa was the only abnormality seen. In none of these cases were hydatid elements obtained at bronchoscopy, although in a case not included in this series, one of us (M.R.J.) established a diagnosis by bronchoscopic removal of a piece of hydatid membrane.

Bronchograms were performed in only four cases; in one no abnormality was found, in one the dye was shown entering a cyst, and in two cases displacement of bronchi was seen.

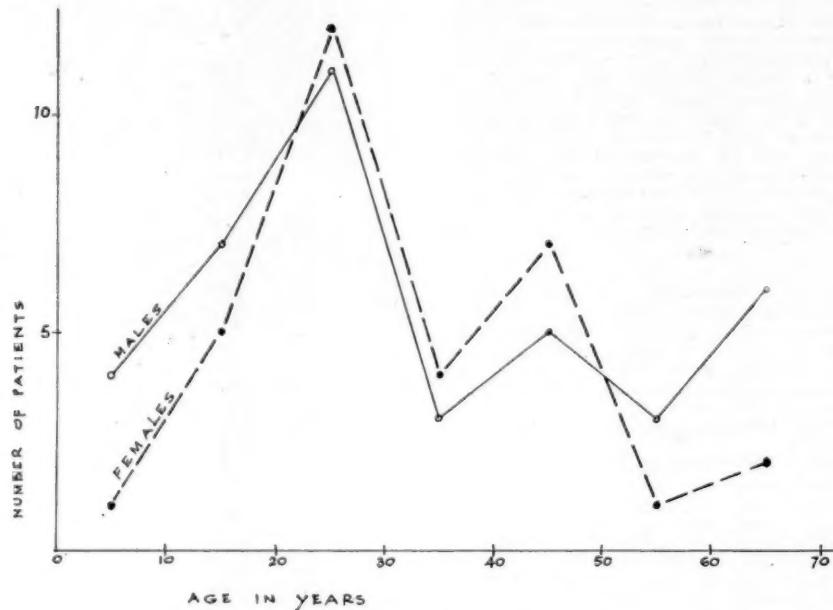


FIGURE 1.

In every suspected case of hydatid disease both tests should be performed; but, of course, a positive result does not necessarily mean that the rounded shadow in the lung for which a diagnosis is being sought must be a hydatid cyst.

In nine cases microscopic examination of sputum showed some hydatid elements. In six of these cases there was a history of expectoration of hydatid fragments, in two there was a broncho-biliary fistula, and in one a ruptured hydatid abscess was present. In 32 cases microscopic examination for hydatid material was not performed. The result of the hydatid complement fixation test was positive in all these cases in which it was performed, but a positive response to the Casoni test was obtained in only four of the six cases in which it was done.

Significant eosinophilia (over 600 per cubic millimetre on a differential count) was present in 20% of cases; in four of these there was a history of expectoration of hydatid material, or this was found on microscopic examination of the sputum.

Of 22 cases of simple hydatid cyst in which the diagnosis was proved at thoracotomy, in 30% the Casoni test produced a positive result, but in only two of the seven cases in which the hydatid complement fixation test was performed was a positive reaction obtained, and in none was significant eosinophilia present. On the other hand, of the 26 cases of hydatid cysts which had ruptured, in 16 the response to the Casoni test was positive, in

In those cases in which a pleural effusion occurs, the fluid should be examined for hydatid elements and for eosinophilia.

Pleural eosinophilia in association with eosinophilia in peripheral blood is almost diagnostic of hydatid disease in this country. One of our patients, who had a rupture of a hydatid cyst of the liver into the right pleural cavity with consequent effusion, had 90% eosinophilia in the pleural fluid and an absolute eosinophil count in the peripheral blood of 855 per cubic millimetre. In another case in which a hydatid pyopneumothorax was present, a hydatid complement fixation test was done on the pleural fluid and produced a positive result.

In 72.5% of cases, abnormal physical signs in the respiratory system were recorded, but they were in no way diagnostic.

Surgery of Hydatid Cysts.

The main surgical procedures that were carried out on these 65 patients under review are shown in Table V.

It is generally agreed (Barrett, 1952; Officer-Brown, 1958) that every hydatid cyst, irrespective of its pathological state, should be surgically removed as soon as it is diagnosed, as the danger of thoracotomy is less than that of spontaneous rupture.

Until June, 1957, the most common operation at this hospital was excision of the cyst with tube drainage of the cyst cavity. Since then, Barrett's type of operation

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(excision of the cyst with obliteration of the cavity) has become the standard procedure, and it has considerably reduced the period of hospitalization (Table V). Obliteration of the cavity is very important, as it decreases post-operative morbidity and recurrence in the space. The hydatid cavity may be sterilized by iodine or eusol before it is closed, but formalin, which is a strong pulmonary irritant, should not be used. Susman (1960) also advocates the removal of adventitia.

TABLE II.

Symptoms.	Frequency. (Percentage.)
Cough	73
Pain	70
Sputum	56
Hæmoptysis	45
Dyspnoea	39
Toxic	23
Membrane in sputum	20
Weight loss	15
Asymptomatic	12
Allergic	8

Lobectomy is now advised only in cases in which there has been severe secondary infection (for example, bronchiectasis or a chronic abscess in a ghost cyst), or very rarely if there is severe haemorrhage at operation (Susman, 1948, 1950). It will be also carried out in cases presenting unusual features in which the diagnosis of hydatid disease has not been made even at operation—for example, when a collapsed cyst has simulated carcinoma.

TABLE III.
Site of Single Cysts in the Lung.

Site.	Right Lung.	Left Lung.
Upper lobe	6	9
"Middle" lobe	5	1
Lower lobe	14	9
Lobe "not stated"	3	6
Total	28	25

A two-stage operation, to produce adhesions around the cyst in order to prevent local spilling of hydatid elements, may lead to many complications, and should be abandoned.

Decortication is performed in cases of hydatid empyema or fibrinous pleurisy with cysts in the pleura, and cysts of the lung or liver and the hepato-bronchial or hepato-pleural fistulae are dealt with at the same time.

In five cases in this series no surgery was performed: in two, asymptomatic hydatid cysts were found at autopsy, two "cured" themselves by endobronchial rupture of the cysts, and one patient died from hydatid anaphylactic shock before any definitive surgery could be performed.

Two patients died after operation, one from secondary haemorrhage and the other at the end of the operation, either from obstruction of a bronchus by hydatid material or from anaphylactic shock. These two cases were excluded when average post-operative hospital stay was calculated.

Study of Readmissions.

There were 49 readmissions to this hospital during the 1945-1960 period in the 72 cases reviewed. In 10 of these, surgery was not employed on the first admission, but the operations performed on these patients were discussed in the last section, and two had been previously admitted to another hospital for surgery. Therefore, these 72 patients had in fact 41 readmissions because

of sequelae of their pulmonary hydatid disease. The readmissions involved 23 patients, of whom 15 were males and eight females. Ten patients (14% of this series) had recurrence of hydatid cysts, eight had pulmonary symptoms only, three were admitted to hospital because of post-operative complications (one of these being infection in a post-hydatic space), and two were admitted for review. All known patients with recurrences were operated upon within four and a half

TABLE IV.
Pathological Tests.

Test.	Percentage of Positive Results.
Hydatid complement fixation test	55
Casoni test	47
Test for eosinophilia	20

years of their previous operations. A single recurrence took place in all but one patient, who had recurrences on four occasions. The interval between initial admission to hospital and surgery for recurrences was less than six months in four cases, one to three years in six instances, and over three years in three cases. The cysts were single in only two cases and multiple in eight. They were in the pleura and/or chest wall of the side operated upon, except in two cases in which the recurrence was in the lobe previously operated upon, and in two others in which there were numerous cysts in each lung.

TABLE V.

Operative Procedure.	Number of Cases.	Average Total Hospital Stay. (Days.)	Average Post-Operative Hospital Stay. (Days.)
Barrett's operation	10	20.8	16.7
Removal of cyst with drainage of cyst cavity	23	51.5	35.1
Two-stage removal of cyst	5	77.0	53.4
Excision of cyst only	3	77.0	57.3
Lobectomy	3	28.8	16.7
Decortication	6	37.4	25.8
Surgery of liver hydatid with or without pulmonary surgery	7	101.3	96.0
No surgery at all	5	12.6	—
Multiple surgery	3	111.7	—
Total	65	52.8	—

Eight patients (five males and three females) were admitted to hospital because of pulmonary symptoms, but no recurrence was found. All these patients had cough and sputum, six had haemoptyses, and three gave a history of coughing up fragments of hydatid membrane. Five patients complained of pain in the chest, and two had pneumonic episodes at some stage after their operation, but none complained of undue dyspnoea.

Bronchoscopy was performed on five of the readmitted patients; but, apart from congested bronchial mucosa in three and displacement of a bronchus in one, no abnormality was seen. In one patient part of a laminated membrane was removed. Bronchography was performed in only five patients who had haemoptyses, but in only three were bronchiectatic changes demonstrated, and distortion or displacement of the bronchial tree was present in each case.

The result of the Casoni test was positive in six cases, but in only two of these was there any evidence of active echinococcosis; on the other hand, of four cases in which the result of this test was negative, hydatid cysts were found in three. The result of the

hydatid complement fixation test was positive in one case in which there was no evidence of active disease, and negative in two cases in which there were known hydatid cysts and in three others in which there were no recurrences. None of the patients readmitted to hospital showed eosinophilia before operation, but this developed in two after surgery.

Among the patients reoperated upon for recurrence there was one further death due to post-operative hydatid pulmonary artery embolism; this brings the total number of operative deaths in this series to three.

Follow-up Investigation.

A follow-up study was made of these patients to determine their present clinical status. This was done by sending a request for them to come to the hospital for review, or if this was not possible, to reply to a questionnaire. When possible a history was taken, a clinical examination was made, and X-ray examinations of the chest, blood counts and Casoni and hydatid complement fixation tests were performed. Two of the 72 patients could not be traced.

Eleven of the patients had died, six from causes unassociated with their hydatid disease, one from fatal anaphylactic shock after rupture of a cyst into the right ventricle, one from pyelonephritis secondary to paraplegia from a spinal hydatid, and three after operation, as previously stated. Autopsy was carried out on six of these patients: two of them had hydatid cysts in the heart only (one had previously had a pulmonary cyst removed), one had no hydatid cysts (having had a single pulmonary cyst excised previously), and three had cysts in both liver and lungs, in addition to a recurrent cyst in the vertebral column in one patient and embolic cysts in both pulmonary arteries in another.

Five patients are still under treatment, three being in hospital at the time of writing and two awaiting admission for further surgery to pulmonary cysts.

Twenty-eight patients were interviewed by one of us (R.W.H.), a number journeying from the country for the purpose. All these patients had absolute eosinophil counts below 406 per cubic millimetre. The result of the hydatid complement fixation test was positive in 13 cases and negative in 15. The immediate Casoni reaction was positive in five cases and negative in 21, while the delayed reaction was positive in 12 and negative in 10. Chest X-ray films showed normal lung fields in 14 cases, in 10 there was fibrosis at the site of operation but no other abnormality, and in one case there was a small calcified area in the adventitia of a previously removed cyst. Ghost cyst was seen in only one patient; he had evacuated his cyst by coughing hydatid material in 1940, this being followed by bronchoscopic aspiration, since when he has had minor haemoptyses. In two cases, in which bronchograms were performed because of suggestive symptoms, bronchiectasis was found in the lobe from which the hydatid cyst had been removed. Three other patients already mentioned were also shown to have residual bronchiectasis. In none of these 28 patients was a hydatid cyst detected.

The follow-up study of 26 patients is confined to replies to their questionnaires or letters from their attending doctors. No laboratory tests could be performed on these patients, but all but four of them are known to have had chest X-ray examinations, and in none is there any evidence of recurrence of the cysts. Fibrosis at the operative site is present radiologically in at least four of these cases.

All the 54 patients no longer under treatment are back in their normal occupations; 35 are considered to be symptomless, while 19 patients have some symptoms. Twelve complain of pain in the chest, seven complain of dyspnoea, and six have recurrent small haemoptyses. One, who had a cerebral hydatid cyst removed, suffers from epilepsy, and one has a chronic empyema which has been draining for two and a half years.

It was previously shown that all the recurrences in this series occurred within five years of the initial operation. Thirty-six patients were treated for the pulmonary hydatid cysts before 1955 either at this or another hospital and are still alive, and of these seven (nearly 20%) had one or more recurrence, in the same lung, or in the pleura or chest wall on the same side. One patient had had a hydatid cyst of the lung removed 16 years before her readmission to hospital with a ruptured hydatid cyst of the heart.

Prevention.

Theoretically, hydatid disease should be easily prevented by simple measures which would break the life cycle of the parasite and prevent human infestation, yet in the last 30 years there has been no decrease in the rate of sheep or dog infestation, and no decline in the number of patients with this disease treated at this hospital during the period covered by this survey. Five of the 72 patients studied died directly as a result of hydatid disease, and when in addition one considers the recurrence and morbidity rates in this series, which deals only with thoracic hydatid disease, the importance of the disease in this State cannot be denied. We estimate that at least 1000 patients have been treated for hydatid disease in the last 20 years, in this State alone.

The methods of prevention are simple and should be known to graziers, yet are commonly ignored. Professor H. R. Carne (1960) advises that all offal should be boiled before it is given to dogs, and as this would break the life cycle of the parasite, it should speedily lead to elimination of the disease if it was consistently carried out. The effective de-worming of dogs by the use of arecoline hydrobromide (one-sixteenth of a grain per 10 lb. body weight of dog given orally), as stressed by Barnett in 1937, would also break the cycle, but would be of only temporary benefit unless further access of the dog to infected offal was absolutely prevented. Air-borne infection has never been proved, and there is little doubt that in almost every case the ova are ingested via contaminated fingers, food or water. Attention to elementary hygiene should prevent this, especially the washing of hands before meals. As the infection may be acquired in childhood, this naturally involves adequate parental supervision, including the prevention of the fondling of possibly infested dogs by children. From our experience it appears that more propaganda regarding the disease and its prevention is required in sheep districts.

Summary.

All patients with intrathoracic hydatid disease admitted to Royal Prince Alfred Hospital between 1945 and 1960 have been studied. There were 72 patients who had 116 admissions to this hospital, and there has been no diminution in the admission rate throughout this period. Males were affected more often than females in the proportion of 1.3 to 1.0; the maximum incidence was in the 11 to 30 years age group, and the vast majority (at least 68) are considered to have acquired the disease outside the metropolitan area. In recent years, 14% of cases were discovered by routine radiographic examination. Recurrent haemoptyses took place in 32% of patients, and 20% gave a history of expectoration of hydatid material. Allergic and anaphylactic reactions were rare. The right lung was only slightly more frequently involved than the left.

Laboratory tests were helpful in cases of hydatid cysts which had ruptured or leaked, but in the case of unruptured cysts, often present radiologically as a round lesion of doubtful aetiology, these tests were rarely helpful. The examination of pleural fluid from a patient with possible pulmonary hydatid disease should include the hydatid complement fixation test and a search for eosinophilia. Physical signs when present were usually non-specific, and although the diagnosis may be made by consideration of the history, radiological findings and

laboratory tests, thoracotomy is frequently required for diagnosis as well as for treatment.

Ninety-seven *per centum* of the patients have been successfully followed up; 20% of those treated more than five years ago have had recurrences of their cysts; five patients died directly as the result of the hydatid disease.

Acknowledgements.

We would like to thank Dr. E. Thomson, the General Superintendent of the Royal Prince Alfred Hospital, for permission to study the hospital records. The work of one of us (R.W.H.) was made possible by a special grant to the Thoracic Unit, arranged by Dr. H. M. Rennie, to whom we express our thanks. We are also indebted to the staffs of bacteriology, radiology, haematology and records departments for their cooperation in this study.

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Reviews.

Obstetrical and Gynaecological Pathology for Post-graduate Students. By R. E. Rewell, M.D. (Lond.), M.R.C.P.; 1960. Edinburgh and London: E. & S. Livingstone Ltd. 8*½*" x 5*½*", pp. 448, with many illustrations. Price: 50s. net. (English).

For many years obstetricians and gynaecologists have been keenly aware of the benefits to be derived from an intelligent understanding of the pathology of disease processes within the orbit of their specialty, and have demanded a similar awareness and knowledge from aspirants to that specialty. Authoritative texts on gynaecological pathology (unjustifiably including "obstetrical" in their titles) and neonatal pathology have been available and widely acclaimed for nearly a quarter of a century, but the extent and detail of their coverage has been more suitable for pathologists than for clinicians. The present book has been produced to cater for clinicians rather than for pathologists, and commendably covers obstetrical as well as gynaecological pathology; it also includes a short but good section on neonatal pathology, and useful chapters on important

haematological conditions encountered frequently in the practice of obstetrics and gynaecology.

In the compilation of this volume numerous publications have been consulted, and the author has reproduced the opinions expressed by these papers faithfully; too often he leaves the reader in a rather bamboozled state by not giving a definite lead as to which of conflicting theories is correct, or even the more probable, in the light of his own experience. Indeed, some of the references are to rather valueless contributions and might well have been omitted.

The sequential arrangement of chapters is logical, with the exception of the one dealing mainly with puerperal infections, which could have been placed more appropriately after the chapter on maternal mortality and morbidity.

Considering the size and scope of the work, quite liberal use has been made of photomicrographs; many of the high-power ones are excellent, but many at lower magnifications are not good—sometimes, in fact, too poor to merit the space they occupy.

Unfortunately there is a patchy occurrence of incorrectly spelt words, such as "chromosome", "carryorhexis", "lumena", "alveole" and "vestibule", and on pages 80 and 84 "myeloblasts" and "myeloblastoma" when myoblasts and myoblastoma are obviously meant. Again, on page 341, "blood prothrombin level" should surely read "blood fibrinogen level". These errors are irritating.

Inevitably pathologists will differ in their opinions, not only on the interpretation of slides, but also on more general aspects of disease. We disregard minor differences of opinion from those expressed in the book, but disavow such statements as the following: that leukoplakia of the cervix shows no tendency to malignant change (pages 100 and 152); that all squamous carcinomas of the cervix go through the intraepidermoid stage (pages 111 and 112); that five minutes is adequate for cytological examination of a cervical smear (page 254); that no unpleasant consequences have followed the use of fibrinogen (page 343—a high incidence of viral hepatitis was reported in a New York series so treated); that heparin does not influence the one-stage prothrombin time (page 344); and finally, the serum bilirubin levels above or below which kernicterus invariably does or invariably does not occur (page 367). With regard to the last-mentioned, Dr. Rewell states that neurological sequelæ always supervene in babies with serum bilirubin levels above 30 mg. per 100 ml. and that neurological sequelæ never occur in those with levels below 20 mg. per 100 ml. There are exceptions in both directions to this rule—so many, in fact, that a few thoughtful pathologists and clinicians still remain unconvinced by the evidence presented to date implicating bilirubin *per se* as the aetiological agent in such brain degeneration.

Occasional topics could have been discussed a little more fully, and the condition of mixed squamous carcinoma and adenocarcinoma of the cervix uteri has not even been mentioned.

Some criticisms having been offered, it is also pleasing to be able to comment that the over-all presentation of subject matter in this book is original and good. Several sections, particularly those on endometriosis, genital tuberculosis, endocrinological aspects of the placenta, birth trauma, sex chromatin, and leukoplakia of the vulva (except for the reference to cervical leukoplakia), are excellent and deserve specific mention. The author's purpose is stated clearly at the beginning of his preface, and it is believed that this purpose should be largely achieved.

Clinical Psychiatry. By W. Mayer-Gross, M.D., F.R.C.P., Elliot Slater, M.A., M.D., F.R.C.P., D.P.M., and Martin Roth, M.D., F.R.C.P., D.P.M.; second edition; 1960. London: Cassell and Company Ltd. 10*½*" x 7", pp. 724. Price: 90s. 9d.

In the preface to the first edition of this book, the authors stated that their reason for writing another textbook of psychiatry was to review and consolidate the great advances made in this subject during the last 30 years. They also emphasized that such a presentation should be based on scientific method as used in other branches of medicine. For this reason, the general background of this book is based on an organic approach to the subject of psychiatry. In general this results in an unduly detailed discussion of aetiology, with a lesser emphasis on the details of treatment.

The authors hope that this work will be useful for students, general practitioners and workers in allied fields. For a textbook to serve in this way, it is important that perspectives in the subject should be well defined, and that

an adequate discussion should be given to the common, and usually minor, disorders of psychiatric practice. The introductory chapter, on the foundations of psychiatry, presents a satisfactory review of this aspect, but the rest of the book is hardly suitable for this group of workers. This is borne out by the following statement on history-taking:

Psychiatrists of other schools have learned much from psychobiological teaching. But, in the opinion of the authors, it has led to a lack of sense of proportion, to a forgetfulness of patho-physiological factors, and an immersion in detail which have not in the long run been profitable. They favour, therefore, a somewhat more violent method. If treatment is to be begun when it has the best chance of success, a provisional diagnosis at least, should be reached within the first week after the patient's admission.

Such an approach would be unpractical for the majority of psychiatric disorders seen in the psychiatric doctor's consulting room. This attitude fulfills the other wish of the authors—that this book should be useful as a source of reference to the psychiatric consultant. This undoubtedly is its main function, to provide a very useful outline of various viewpoints, especially the organic ones, on the disorders commonly seen in a consulting psychiatric practice.

On the Causation of Varicose Veins and their Prevention and Arrest by Natural Means: An Evolutionary Approach. By T. L. Cleave, M.R.C.P. (Lond.), with a foreword by Harold Dodd, Ch.M., F.R.C.S.; 1960. Bristol: John Wright and Sons Ltd. 7*1*" x 4*1*", pp. 32. Price: 7s. 6d. (English).

This small book analyses the western way of life, and in particular, the effects of food on the function of the colon. The delay in the passage of its contents affects adversely the circulation in the lower limbs, the lower bowel and the spermatic veins, leading to varicose veins, femoral thrombosis, haemorrhoids and varicocele.

Darwin's theory of evolution is given a place of importance in this book, particularly the remarkable adaptation of all species to natural environment. Also of importance is the adaptation to an unnatural or new environment. This, however, requires an adequate period of time.

So in varicocele, the cause of the condition is not the arrangement of the spermatic veins, which differs on the two sides, but which is normal in the total anatomy of the abdomen under natural conditions. Rather is the cause to be found in the delayed passage of colonic contents, as opposed to the natural rate. This delay in its turn is due to the removal of some fibre from cereals and of all the fibre from sugar-cane and sugar-beet.

Similar reasoning applies to haemorrhoids, varicose veins and femoral thrombosis. The colon is not incriminated, but rather the food of modern civilization. The body is not wrongly built—it has followed the law of adaptation—but is being wrongly used. The wrong is the refinement of our diet. The theory is an interesting one, but many aspects of varicose veins are not explained by it. It is doubtful whether efforts to effect vast alterations in our dietary régime would be justified.

Radioactive Wastes: Their Treatment and Disposal. Edited by J. C. Collins, B.Sc., M.S.E., A.M.I.C.E.; 1960. London: E. & F. Spon Limited. 8*1*" x 5*1*", pp. 266. Price: 55s. net. (English).

THE book contains about 200 pages. It is divided evenly into five chapters concerning the origin, nature and radio-biology of radiation, the sources of radioactive wastes and the law concerning these wastes in Great Britain, and another five chapters dealing with the disposal, discharge and treatment of radioactive waste. The first half of the book therefore explains the magnitude of the problem in physical and biological terms that have been carefully and accurately defined and explained. Most books concerned with radiation effects of one kind or another have an adequate chapter on nuclear physics, but the chapter in this book is quite outstanding. The second half of the book is given to the measures designed to solve the problem by scientists associated with the U.K.A.E.A. at Harwell and elsewhere.

It deserves to be read widely by those associated with the problem of radioactivity as a health hazard, as well as by the engineers and technologists for whom it is primarily written. It is well presented, and the standard of printing and general format are a credit to the publisher. Some minor criticisms will be made by medical and biological graduates in the chapter about the hazards of radiation. For instance, one must quarrel with the misconstruction that blood changes are symptoms of acute radiation sickness. The

statement that there is always some chance of survival, however large the dose of radiation received, is in the same category as another statement that the whole of the body content of fluorine, phosphorus, calcium, barium and radium is in the skeleton. Doubtless the biologist misconstrues his physics just as much to the irritation of the physiologist; but we believe that at least part of this chapter would have been more usefully written for the book by a biologist. In this chapter also, tritium is given a half life of 33 years. However, these irritations are assuaged by the remainder of this interesting and important work.

Surgical Aspects of Medicine. Edited by H. Daintree Johnson, M.A., M.B., B.Chir., F.R.C.S.; 1959. London: Butterworth & Co. (Publishers) Ltd. 9*1*" x 6*1*", pp. 404. Price: 90s. (English).

ONE of the unfortunate features in a specialist's life is the lack of contact with the proliferating edges of other disciplines. Most surgeons retain as concepts of internal medicine their undergraduate teaching of a generation or two before. Similarly the physician, unless he has time to spend at hospital conferences or reads exceptionally widely, tends to be restricted in his understanding of present-day surgery. Mr. H. Daintree Johnson has edited a book of articles by a number of surgeons designed to overcome the prejudice of the physician towards the operative management of disease.

The range of topics is a wide one—from the alimentary tract, through the genito-urinary system, lungs and heart to the brain and special senses. Indeed, the scope of the book is so great that it becomes almost too diffuse. It is unlikely that even the most general physician will be interested in the details of minor injuries and painful feet while at the same time trying to understand the surgical viewpoint on circumcision or squint. Nevertheless, some chapters are well written, and although presenting a personal viewpoint, make good reading. We would recommend especially Peter Martin on peripheral ischaemia and the writing of the senior author on reflux oesophagitis. Unfortunately much of the text is occupied by somewhat elementary classification and clinical description of disease, an area in which the physician needs little prompting, and the book as a whole possibly aims at too wide an audience.

While the need for reeducation between specialities is very great, it would seem that such a book could with advantage be more eclectic, and focused more sharply on the common territories in which the rapid expansion of surgery has changed in emphasis or raised the standard of operative therapy.

Projective Techniques with Children. Edited by Albert L. Rabin and Mary R. Haworth; 1960. New York, London: Grune & Stratton Inc. 10" x 6*1*", pp. 406, with illustrations. Price: not stated.

THIS book represents original contributions by 22 authors. It is a book for the clinical psychologist and the research worker principally, but it should be of interest also to psychiatrists and social workers who work in the field of child psychiatry.

All tests used in personality evaluation, especially those for use with children, have their shortcomings; hence the wide variety of projective techniques which have been devised, and which are discussed in this book. The projective test can provide a wealth of material, and a record of the experience of a number of psychologists in the use of projective tests is a valuable help to others in the interpretation of responses.

As is pointed out repeatedly in this book, tests can be interpreted only in the light of information already obtained about and from the child. A knowledge of norms for different ages and sexes and socio-economic levels is also necessary for accurate interpretation of clinical material, and reference is made to norms where they have been established. There is a healthy awareness by the authors of the part played by the personality as well as the experience of the psychologist in the evaluation of the child's responses. It is encouraging to see a chapter on the projective aspects of intelligence tests, and to note the emphasis on the fact that personality variables are involved in intelligence testing.

The field of projective techniques in children is well covered in this book. Extensive references accompany each chapter, and suggestions for future research are made by many of the authors. The chapters are well written and freely illustrated by case material, and the book is an excellent guide for newcomers to the field of projective testing, and a reference work of value to those already experienced in the use of these tests.

The Medical Journal of Australia

SATURDAY, MARCH 11, 1961.

A VISION OF COMMONWEALTH MEDICINE.

SIR DOUGLAS ROBB's presidential address to the annual meeting of the B.M.A. in Auckland recently¹ is of first-rate importance, and this not least to the medical profession in Australia and New Zealand. It presents to us a picture of what medicine could be like if throughout the Commonwealth countries there was a spirit of sharing and a sense of responsibility to one another without either patronage on the one hand or loss of human dignity on the other on the part of any country. This is related to three aspects of medicine: medical and health services, medical training and medical research. In all these, as Sir Douglas Robb makes clear, there are gross inequalities as between one Commonwealth country and another, and this should fill us with real concern, if not shame. But it is not only a matter of adjusting inequalities; the one-way passing of aid is a very inadequate concept. Every country has in one way or another something to give for the common good, and it is just as important to learn to receive as it is to give out of material bounty and so be tempted to pride and self-satisfaction. The essential thought is that this should be activity within a family—something that still seems impossible on a world basis, but that should be possible within the Commonwealth.

We hope that Sir Douglas Robb's address will be read carefully and sympathetically in this country, for ours is not the least of the countries of the Commonwealth and our destiny is undoubtedly closely bound up with that of the Asian countries in the family. Already important medical links have been formed with South-East Asia, especially through the Colombo Plan and through the activities of the Royal Colleges. Activity in this field may well be an important responsibility for our new national medical association, especially if the Commonwealth Medical Association proposed in Auckland eventuates. Admittedly one implication of the plan will not immediately appeal to us, at least as things stand at present—the idea of a health service in each country of the Commonwealth on a universally acceptable basis. There is wide divergence between our own health service and those of certain other Commonwealth countries, particularly in relation to principles that we regard as vital, and only radical changes in the outlook of governments and even of the profession would make the idea feasible. This, however, should not be made a stumbling block. It is important to remind ourselves that the principles on which the profession has laboured with considerable success to have the Australian National Health Service

based are those of the World Medical Association, to which the medical associations of all of our Commonwealth countries belong. If some existing health services violate those principles, that is by no means a reason for abandoning the principles or regarding them as impracticable. Rather is it a sound reason for underlining them and, both directly and through the World Medical Association, encouraging our colleagues in other Commonwealth countries to work for their recognition. Meantime, as Sir Douglas Robb has indicated, there are other aspects of health and medical services in which there is room even now for increased mutual cooperation. As to the educational and research fields, if we go on building on what has been and is being done, keeping our minds open to possible developments and cultivating the concept of the unity of the Commonwealth as a family of nations, we may go a long way toward achieving something that even on the lowest level, that of self-interest, is highly desirable. If Sir Douglas Robb's concluding remarks are borne in mind about the importance of compassion and imagination, we shall achieve something very much higher.

Some people will regard Sir Douglas Robb's ideas as wholly visionary and so unrelated to reality that they are impracticable. He himself says quite frankly that he does "ask to see the distant scene". But some of his ideas are practicable now and are indeed being put into effect in one way or another; the future practicability of others may be reasonably foreseen. If in our more hard-headed moments we balk at some parts of his vision, let it be said that we seldom accomplish the whole of the possible in matters like this if we do not start off with a bit of the impossible in our minds as well. And the passing of many centuries has not discredited the statement that where there is no vision the people perish.

THE NEW ZEALAND MEETING.

THE New Zealand Meeting of the British Medical Association, held in Auckland last month, must be voted a great success and a legitimate source of gratification to all who had a hand in organizing it. Combining the one hundred and twenty-ninth annual meeting of the Association with the biennial meeting of the New Zealand Branch, it brought together a substantial contingent from the United Kingdom (including most of the senior office-bearers of the Parent Body), representatives of major Branches of the B.M.A. and affiliated associations throughout the world, and a large proportion of the doctors of New Zealand. It was a unique event in the experience of the medical profession in New Zealand to date and one not likely to be repeated, at least within a generation. The New Zealand Branch showed great enterprise and even daring in inviting the Association to meet within its territory, but the result was wholly admirable. By no means least was the spontaneous warmth of hospitality and the efficiency of organization which made nothing appear a trouble—a fine achievement for a Branch with only two and a half thousand members. In this regard, although it is difficult and perhaps risky to single out individuals, great credit must go to the Honorary Joint

¹ Brit. med. J., 1961, 1: 375 (February 11).

Secretaries of the meeting, Mr. Anthony Hunter and Dr. Peter Bartley.

A brief account of the meeting appears elsewhere in this issue (see page 389). We have not attempted to present it in greater detail as it is fully reported in the current issues of the *British Medical Journal*, and in any case it was not primarily Australia's meeting. However, the Australian Branches, as part of the Association, were given a substantial and honourable part in the scientific programme, and every way in general the Australian visitors were made to feel very welcome guests. Perhaps one of the most important side effects of the meeting from our viewpoint was the cementing of friendly relations with our colleagues in New Zealand, of whom we see all too little. It would be most gratifying, and would provide an excellent opportunity to attempt to return friendly hospitality, if a substantial contingent of New Zealanders would visit Australia in May, 1962, for the Adelaide Congress, which may well be an historic occasion.

Current Comment.

THE RADIOLOGICAL APPEARANCES OF SYNOVIAL OSTEOCHONDROMATOSIS.

SYNOVIAL OSTEOCHONDROMATOSIS is a rare condition, the literature of which has been confused by the inclusion of various conditions which bear a superficial resemblance to it. H. L. Jaffe¹ has stated that the term should properly be applied only to a condition in which cartilaginous foci develop in the synovial membrane of a joint through metaplastic changes in the subsynovial connective tissue. The cartilage may then separate from the synovium, enlarge in the joint space (since it can be nourished by synovial fluid), and ultimately become calcified or ossified. Two cases have recently been described by C. Zimmerman and V. Sayegh,² with special emphasis on the radiological appearances of the lesion. They state that this is most frequently seen in adults between the ages of 30 and 50 years. The knee is the most common site of involvement, although other joints such as the elbow, ankle, hip and shoulder are infrequently affected. Bilateral involvement is rare. The patient usually presents with a long-standing history of intermittent dull aches associated with limitation of motion and occasionally accompanied by locking and grating sensations. Joint deformity is usually apparent, fluid may be present, and movable or fixed masses are often palpable. There is often surprisingly little interference with function when the size of the cartilaginous masses is considered. The X-ray findings are as follows: (i) Soft tissue masses of water density are found within the involved joint. These represent the thickened, encrusted synovium as well as free cartilaginous joint bodies and are often rounded in contour, against the relatively radiolucent adjacent fat spaces. (ii) Areas of calcification and/or ossification may be seen and represent synovial metaplastic changes to cartilage, sufficiently calcified so as to be radio-opaque. These radio-opaque areas are generally finely stippled and often coalesce to form amorphous irregularly bordered shadows which may involve the entire joint space or only a portion of it. There need be no relationship between the amount of radio-opaque cartilage and the extent of joint involvement by synovial metaplasia. (iii) There may be erosion of adjacent subchondral bone. This finding is related to pressure from adjacent extensively thickened synovium or free bodies, and results in radiolucent areas within the bone. These areas are rimmed with a sclerotic zone,

attesting to the chronicity of the change. No real destruction or subperiosteal new bone formation occurs. (iv) Secondary arthritic changes occur. These result from the constant mechanical trauma of the metaplastic bodies and synovial projections, and include osteophyte formation, thinning of articular cartilage and the presence of small amounts of fluid. Synovial osteochondromatosis must be differentiated from other conditions with articular calcifications and ossifications, soft tissue masses in the joint and loose body formation. Osteoarthritis frequently involves the knee joint and may be associated with osteophytes which break off and become loose bodies. The latter, however, are generally fewer in number than in synovial osteochondromatosis and are larger, coarser and often have radiolucent centres. Osteoarthritis secondary to true synovial osteochondromatosis can occur but is mild, and lesions will retain the fine, coalescent stippling of the primary entity. Pigmented villonodular synovitis presents with nodular articular soft tissue masses, but calcification is almost always absent; a dark brown or serosanguinous fluid is often obtained when the joint is aspirated. Synovial sarcoma usually originates from para-articular soft tissues rather than from within the joint; differentiation from synovial osteochondromatosis may be difficult, especially if bone erosion and destruction cannot be distinguished. However, a large extraarticular mass with adjacent bone destruction rather than erosion is suggestive. Calcification is not infrequent in synovial sarcoma and its presence is therefore not helpful in differentiation.

The treatment of synovial osteochondromatosis involves the surgical removal of all accessible loose bodies to prevent mechanical articular damage. In addition, synovectomy is performed to exclude a potential source of new intraarticular masses. Surgery is generally successful although the results are modified by the degree of secondary osteoarthritis present before operation.

JOHN CONOLLY (1794-1866).

IN 1849 John Conolly, Medical Superintendent and then Visiting Physician (1839-1844) at the Middlesex Lunatic Asylum at Hanwell (now St. Bernard's Hospital), delivered a second series of Croonian Lectures.¹ The interest of these lectures lies not so much in the descriptions of the patients who had been under his care, classified under the few broad diagnoses current in his day, as in his claim that they had been "divested of the aggravations and disguises resulting from violent methods of control and positively from all habitual exasperation by violence". Two of the six lectures were devoted to general paralysis, "so distinct and peculiar in its character". Following descriptions by Delaize in 1822 and Calmeil in 1826, Conolly gave as the leading features the higher incidence in men, onset in middle life often with epileptiform convulsions, change of character with extravagance and ostentation, speech which becomes "lingering", "legs which are observed to be a little unsteady", and a rapidly fatal course. Dr. Arnold's water-bed, a container covered with impervious material, was found valuable in the prevention of bed-sores, and a modification of this curious furniture was in use at the hospital as late as 1922. In the Hanwell casebooks of the middle of last century the diagnosis of "general paralysis" was applied freely and with less exact adherence to the original criteria in cases with mental deterioration.

Conolly, not alone in introducing more humane methods of care, was the first medical superintendent of a public asylum in England to abolish completely all methods of mechanical restraint. When he assumed charge of the 800 inmates of Hanwell in 1839, 40 patients were under constant restraint, and he found a stock of 600 instruments, including coercion chairs, handcuffs and leg irons,

¹ "Tumours and Tumorous Conditions of the Bones and Joints", 1958, Henry Kimpton, London: 558.

² Amer. J. Roentgenol., 1960, 83: 680 (April).

¹ "The Croonian Lectures: Delivered at the Royal College of Physicians, London, in 1849: On Some of the Forms of Insanity", by John Conolly, M.D., D.C.L.; 1960. Southall, Middlesex: St. Bernard's Hospital Management Committee. 9¹ x 6". pp. 98. Price: Not stated.

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which had been in regular use. Within a few months he had dispensed with all of them and instead made good use of temporary seclusion in the single and protected rooms with which the institution was well provided. By careful selection of attendants and medical assistants and by instruction he gradually raised the standard of care. He condemned general bleeding and violent purgation, but used local cupping and bleeding in selected cases. For restraint Conolly substituted exercise and occupation and instituted classes in general education and instruction in art. Above all he exercised constant vigilance and made frequent visits to the wards by night as well as by day. While conceding that large institutions might be more economical, he regarded them as "unmanageable and hygienically wrong". Hanwell today has 2500 patients. Conolly's pleas for more numerous and better trained medical and nursing staffs, and for instruction of the medical profession in the early manifestations and treatment of mental disorders, are still cogent.

Much of Conolly's enlightened regime was neglected by his successors at Hanwell and elsewhere. Until the introduction of more effective physical treatments, including the newer sedatives, it was common practice to immobilize refractory patients behind long tables and to use restrictive clothing. Royal Commissions held in the present century have established that it is still "not impossible but that offences will come". With patients prone to aggression and resentful of control there is the constant risk of retaliation by those who are charged with their care, a risk which can be reduced by following the principles which Conolly set forth to the satisfaction of the many who came to examine his work. Refractory patients can be managed without violence. But every mental hospital has to develop and maintain a tradition of humane treatment with the support of the community which it serves.

In his clinical descriptions and his comments on the mental disabilities of certain literary and other personages Conolly revealed in these lectures his shrewd insight into personality, while in his care of the patients in his hospital and his views on the relationship between crime and insanity he was a century ahead of his times. The liberal provisions of new legislation and determined moves towards further reduction of restrictions in mental hospitals, including an "open door" policy, make the republication of these interesting lectures specially timely.

FROM VIRCHOW TO SPERANSKY.

M. G. DURMISCHJAN¹ of Moscow has tried to show that A. D. Speransky's² work is not only of world significance but is a logical development of Virchow's cellular theory. Speransky is known chiefly as the purveyor of the treatment of arthritis by spinal pumping. Few of those who have reported on the method^{3,4} have studied his book carefully. As a profession we hunger for practical methods of treatment and are apt to neglect the more important development of ideas. Sir James Mackenzie,⁵ according to R. M. Wilson, often remarked that people complimented him on his polygraph and not on his ideas; he compared himself with an explorer returning from a hazardous trip to an unknown country who found himself famous as the inventor of a rubber boot.

Speransky's work, writes Durmischjan, will be enduring because he has endeavoured to do what Virchow failed to do; he has assigned to the nervous system its proper place in pathology. The extent of control by the nervous system over the tissues can be partially realized only when it is lost. There is a coordinating factor and a nutritive factor—which is not related to the blood supply. In each tissue the cells are coordinated; every organ is capable of affecting all other organs. Speransky has shown, by fitting glass beads in the brains of animals, that many

chronic diseases are dystrophic in character. Moreover, the site of infection is largely determined by the nervous system. The response of the whole organism to local damage depends on the past history of the nervous system. Recurrences and relapses of disease, too, are largely guided by neural influences. The old idea of special trophic nerves is not true because all nerves are trophic.

Speransky's far-reaching investigations were founded on constructive criticism of accepted views. Every year, he wrote, had seen the addition of tens of thousands of researches affecting medicine. New technical methods were being discovered, and new fields of work laid open. Medicine was progressing more than any other branch of science in size of output and in intensity of study. His answer to the question "What is wrong?" was that there was too much and too profound an analysis of details. Extreme specialization has become the hallmark of medicine, and medical science, both in subject matter and in method, has been broken up into separate parts. Speransky's view was that a method was needed capable of unifying contradictory phenomena. A proper analysis must reveal the general laws underlying the mass of particular data.

RADIOLOGICAL HAZARDS TO PATIENTS.

SIR BRIAN WINEYER, Professor of Radiology (Therapeutics) within the University of London, addressing a meeting of the College of Radiologists of Australasia at the Stawell Hall on Thursday, February 16, 1961, gave a foretaste of the contents of the long-awaited report on radiological hazards to patients⁶ by the Adrian Committee, of which he is a member. The report and the newly revised "Hazards to Man of Nuclear and Allied Radiations" are not yet available in Australia. An encouraging feature of the report is the response by those using radiation medically in lowering the genetic dose to the patient while still deriving the benefit of the required information from the examination. Of course, it was known that this could be done by including such devices as confinement of the beam of radiation and better selection of patients, to mention only two. Figures quoted by Sir Brian from the report showed that the genetic dose from all medical radiology in 1957-1958, both diagnostic and therapeutic, was 19.3 mr per person per year. This was made up of a contribution of 14.1 mr from diagnostic radiology, 4.5 mr from radiotherapy of non-malignant conditions and 0.5 mr from radiotherapy of malignant conditions. There was a minor contribution from radioactive isotopes of 0.18 mr and from dental radiography of 0.01 mr. Mass miniature radiography, which has often been erroneously condemned, contributed a meagre 0.01 mr, which surely must represent a handsome ratio of diagnostic usefulness to possible harmful effects.

When one compares the findings for diagnostic radiology with Osborn and Smith's⁷ figures in 1955 before the hazards of ionizing radiation became broadly known, it is both enlightening and encouraging to find a reduction of the genetically significant dose from 22 mr to 14.1 mr in 1957-1958. Doubtless ionizing radiation exposure of the gonads is still being lessened and, in some cases, eliminated, both by even better techniques in the departments well aware of the hazard and by a spread by example through medical radiology generally. Sir Brian concluded that if full cognizance of the recommendation of the report was taken, the genetic dose might be reduced still further to about 6 mr or less. He emphasized that the present levels in the United Kingdom did not call for restrictions in the medical use of radiation and that, balancing the risks against the benefits, it was held that much individual suffering would follow any unnecessary curtailment of these medical radiological services. The arrival of the reports is awaited for perusal at leisure with great interest.

¹ Wien. med. Wschr., 1959, 109: 137 (February 14).

² "A Basis for the Theory of Medicine", 1937, Moscow.

³ Brit. med. J., 1948, 1: 496 (March 13).

⁴ Dtsch. med. Wschr., 1950, 75: 1459 (November 3).

⁵ R. M. Wilson, 1926, "The Beloved Physician: Sir James Mackenzie", 1926, London: 211.

⁶ "Radiological Hazards to Patients. Second Report of the Committee", London: Her Majesty's Stationery Office, 1960.

⁷ Lancet, 1956, 1: 949.

Abstracts from Medical Literature.

DERMATOLOGY.

Giant Condylomata Acuminata of Buschke and Löwenstein.

G. F. MACHACEK AND D. R. WEAKLEY (*Arch. Derm.*, July, 1960) report two cases, one of a giant condyloma acuminatum of Buschke and Löwenstein of the penis, the other of a squamous cell carcinoma in the inguinal region; the second lesion was originally treated as a giant condyloma acuminatum. The authors review the literature. No report of the curing of such a lesion by the application of podophyllin has been found, and the ineffectiveness of such treatment has been emphasized. The histological changes resulting from the application of podophyllin are discussed. The suggestion is offered that the giant condyloma latum of Buschke and Löwenstein because of its remarkable tendency to local recurrence, should be considered a type of squamous-cell epithelioma.

Sensitivity to Hydrocortisone Ointment.

R. CHURCH (*Brit. J. Derm.*, October, 1960) gives the case records of five patients with eczema who developed a sensitivity to an ointment containing hydrocortisone acetate. Patch tests proved this reaction to be due to 26-diol-acetate, a precursor of hydrocortisone acetate. Small quantities of this were present in the final product.

Aspirin in Chronic Urticaria.

R. P. WARIN (*Brit. J. Derm.*, October, 1960) states that 22 out of 70 patients with chronic urticaria developed exacerbations of weals and giant swellings after the administration of aspirin or sodium salicylate. The effect was more obvious when large doses were used and at times when wealing tendency was greater. It is likely that salicylates act as histamine liberators in producing this effect.

Disseminated Vaccinia in Pregnancy.

D. SOMMACAL AND A. B. LERNER (*Arch. Derm.*, August, 1960) report a case of disseminated vaccinia during pregnancy in a patient with active atopic dermatitis who had two other children who had recently been vaccinated. The patient developed disseminated vaccinia which reached its peak at the time of her delivery. Her baby was not affected. The authors point out that the clinical picture may be indistinguishable from that produced by herpes simplex in a patient with eczema. The two viral infections can be differentiated by history of exposure, isolation of the virus and serological studies. The literature was reviewed to check on the possibility of haemogenous transmission of vaccinia virus to the fetus. In 1932 Lynch described the case of a six-month-old fetus with generalized vaccinia after the mother was vaccinated. Lynch concluded that transmission of vaccinia

virus to the fetus was possible though not common. In the authors' case the question of treatment with corticosteroids was considered, but it was felt that this was contraindicated for fear of causing further dissemination of the virus.

"Chymar" Ointment.

T. CORNSLEET AND E. J. CHESROW (*Arch. Derm.*, August, 1960) discuss a new multiple-ingredient preparation ("Chymar" ointment) for topical use, which contains chymotrypsin, a corticoid (hydrocortisone hydrochloride) and an antibiotic (neomycin). The enzymes dissolve necrotic tissue, crusted cell debris, and exudates. Clearing of superposed detritus by chemical débridement removes an impervious barrier and exposes the fresh surfaces of lesions and wounds to the maximum action of the other ingredients. A total of 251 patients were treated with this preparation. Of these, 97 were geriatric subjects with stasis dermatitis and leg ulcers; in a majority of patients in both categories, the condition improved or the lesions healed completely. No other therapy was employed except bed rest. "Chymar" ointment was beneficial because it cleaned the lesions, removed odours, and allayed pain. In 23 patients who did not improve, the lesions were long-standing and extensive or were associated with atherosclerosis and had not responded to other measures. Seventeen out of 28 patients with acne were either improved or cleared of lesions. Eleven out of 14 patients with eczematoid ringworm were favourably influenced. "Chymar" ointment was eminently effective in superficial infections such as impetigo. It was also useful in seborrhoeic dermatitis, pruritus ani, pruritus vulvae, etc. Twelve patients did not tolerate the ointment.

Flat Cutaneous Xanthomatosis.

W. S. STEWART AND O. A. FINN (*Arch. Derm.*, July, 1960) report a case of flat cutaneous xanthomatosis in which the patient also suffered from eunuchoidism, rheumatic heart disease, and myasthenia. No local therapy was given for the cutaneous lesion, but the patient's muscle weakness, which was unaffected by prostigmin, was considered to warrant a trial of androgen replacement therapy. He was given 100 mg. of testosterone propionate intramuscularly twice weekly over a period of six weeks and then 20 mg. of methyltestosterone sublingually daily. After three months' continuous androgen treatment there was no reduction in muscle weakness or any change in the xanthomatous eruption, but there was a moderate increase in the plasma cholesterol level to about 250 mg. per 100 ml.; this returned to the pre-treatment level of 180 mg. per 100 ml. four weeks after withdrawal of the drug. The patient remarked that while on androgen therapy he needed to shave more frequently. The possibility was considered that the xanthomatosis, the heart lesions, the eunuchoidism and the myasthenia might be related in their pathogenesis. In patients with hypercholesterolaemic xanthomas, cardio-vascular lesions are comparatively common, but in those with normocholesterolaemic xanthomas associated cardiac lesions do not occur. In this

case the features of the xanthomatous process were the onset in infancy, the uniformly flat non-infiltrative character of the lesions, and their chronicity and benign course. The literature of this group of xanthomas is reviewed. Chemical analysis of the lipid content of the skin is reported.

Pityriasis Alba.

B. T. WELLS *et alii* (*A.M.A. Arch. Derm.*, August, 1960) present a review of the literature on pityriasis alba and a study of the results in all patients with this diagnosis who had been seen at the Mayo Clinic during the previous ten years. They state that clinically this condition is characterized by superficial lesions consisting of roughly round to oval patches, which are 0.5 to 5 cm. in diameter, white to light pink in colour and scaly, the scales being fine and adherent. The lesions are slightly margined and the borders erythematous and elevated slightly above the normal skin. The condition is usually asymptomatic except for occasional mild pruritus. The lesions are usually limited to the face and neck but may rarely appear elsewhere. The condition is found almost entirely in pre-adolescent children. A definite aetiological agent has never been determined, though many suggestions have been put forward. The authors conclude that pityriasis alba originates as a non-specific erythema with subsequent localized hypopigmentation, secondary to the mild dermal inflammatory reaction and the ultra-violet-screening effect of the hyperkeratotic and parakeratotic epidermis. No evidence is found to support the hypothesis of a bacterial or fungal aetiology. The cause of the primary lesion is unknown, but the authors consider that dry skin is at least contributory. No treatment more extensive than the use of bland lubricants is justified, and the lesions tend to clear regardless of treatment.

Observations on Keratosis Follicularis.

J. N. PENROD *et alii* (*Arch. Derm.*, September, 1960) discuss patients with keratosis follicularis observed to be associated with lesions resembling verruca plana. They state that the histopathology is that of acrokeratosis verruciformis. It is suggested that keratosis follicularis, acrokeratosis verruciformis and their frequently associated palmo-plantar keratoses are varied expressions of the same genetic disorder. The production of the lesion by ultra-violet light, phenol, ethyl chloride spray and full thickness punch grafts was demonstrated. The relationship of sunlight and trauma to keratosis follicularis remains an enigma, but it may suggest avenues for further investigation of the physiодermal processes of this hereditary disease.

Epithelioma following Lichen Planus of the Mouth.

R. P. WARIN (*Brit. J. Derm.*, August-September, 1960) states that it has usually been taught that malignancy never develops in lichen planus of the mouth, but that a gradually mounting number of such cases is being reported. During the past nine years he has seen 53

patients presenting with lichen planus in the mouth. Four developed a squamous-cell epithelioma, two on the inner surface of the cheek, the others on the tongue and lip respectively. In two further cases, patches of leukoplakia have appeared. The importance is stressed of removing all sources of trauma from sharp teeth, dentures and smoking in these cases.

An Unusual Occurrence of Sporotrichosis.

H. D. GARRETT AND J. B. ROBBINS (*Arch. Derm.*, October, 1960) present eight cases of sporotrichosis of the primary cutaneous variety occurring amongst persons living and working in a combination residence and store in Mexico. Positive cultures of *Sporotrichum schenckii* were obtained from the skin lesions of each of the eight patients. In each of the observed cases potassium iodide solution was given orally in the appropriate dosage and all lesions were healed within a period of eight weeks from the inception of treatment. The authors state that a large majority of cases of sporotrichosis are produced by a primary injury to the skin followed by contamination of the wound by *S. schenckii* present on vegetation or other source in the environment. The source of infection in this instance was proved to be *S. schenckii* living on grass which was used in packing pottery for shipment.

Dihydroxyacetone: A Keratin Colouring Agent.

S. BLAU *et alii* (*Arch. Derm.*, October, 1960) state that dihydroxyacetone (DHA) has recently created a great deal of interest in the cosmetic industry and among dermatologists because of its unique ability to "tan" the human skin, imparting a colour which does not wash off; its effect is to colour the keratin yellow-brown to brown. Prophetic patch tests on 200 persons and thirty-day use tests on 25 persons showed no signs of primary irritation or allergic sensitivity. Dihydroxyacetone shows no cross reactivity with paraphenylenediamine. Histological studies show that dihydroxyacetone does not produce an inflammatory reaction after 30 days' use, and that it does not screen out ultra-violet radiation. Several clinical uses of dihydroxyacetone as a covering agent are described.

UROLOGY.

Renal Vascular Hypertension in Children.

J. R. SMITH AND M. L. SAYLOR (*J. Urol.* (Baltimore), July, 1960) state that the causes of persistent hypertension in childhood may be a renal vascular lesion which can be corrected by operation. To determine whether surgical intervention is indicated requires close co-operation between urologist and paediatrician. Primary hypertension seldom occurs in children, and is in the province of the paediatrician. Secondary hypertension is found more frequently; renal

causes are common, and include glomerulonephritis, congenital polycystic disease, Wilms's tumour and advanced chronic pyelonephritis. Congenital renal vascular causes are stenosis or hyperplasia of the renal artery, renal artery aneurysm, and other anomalies of the renal artery. A sudden onset of hypertension should suggest a renal artery lesion. In diagnosis by urological means, separate renal function studies are used as well as retrograde pyelograms and excretion urograms. Arteriography is important. The surgeon may elect to sacrifice a damaged kidney, or repair an occlusive vascular anomaly. If children are permitted to retain their elevated blood pressure, renal efficiency will surely deteriorate.

Hernia of the Bladder.

H. M. SOLOWAY *et alii* (*J. Urol. (Baltimore)*, October, 1960) describe four cases of scrotal bladder hernia, all diagnosed pre-operatively. They state that this condition is only seldom encountered, but could not be called rare. Wakely found it 75 times in 5000 cases of hernia. The condition is thought to be present in some degree in 10% of inguinal hernias in men over 50 years of age. In most cases it is encountered by general surgeons during repair of an inguinal hernia; they merely free the bladder from the cord and sac, replace it behind the symphysis pubis, and then repair the hernia. Little or no attention is given to the bladder-neck obstruction, which is nearly always the cause of this condition. The authors state that true scrotal bladder hernias, as reported in this paper, are rare. The cases described are illustrated by cystograms.

Colocystoplasty for Enlargement or Substitution of the Bladder.

J.-P. BOURQUE (*J. Urol. (Baltimore)*, October, 1960) states that he prefers to use the sigmoid colon for bladder enlargement or replacement rather than the ileum, and gives the following reasons for his preference: (i) the sigmoid colon is already a reservoir; (ii) it is a pelvic organ; (iii) it can be brought down easily into the lower pelvis; (iv) it can be extraperitonealized so that all anastomoses can be made outside the peritoneal cavity; (v) the mesentery of the sigmoid, unlike the mesentery of the ileum, does not partition the abdominal cavity, and thus the risks of early or late intestinal occlusion are less; (vi) the ureters are brought down easily to the new bladder without being much displaced from their natural bed; (vii) the expulsive system of the sigmoid colon is superior to that of the ileum; (viii) this segment of the intestine secretes less mucus than any other, and also reabsorbs less than either the caecum or the ileum; (ix) it forms a large reservoir so that greater bladder capacity can be expected. The author states that 25 such operations have been performed in his clinic, the indications are well established, and the technique is precise and proved. This operation has been performed for enlargement of the bladder, or to replace it entirely, in the following conditions: (a) the small contracted bladder, usually the result of tuberculous infection; (b) obstinate interstitial cystitis,

when all other measures have failed; (c) inoperable cancers of the bladder. Of the 25 patients, 13 were males. The ages varied from 26 to 67 years. There were 7 cases of small contracted bladder, 11 of interstitial cystitis, and 7 of vesical neoplasm. There was only one death, which was due to a cerebral accident on the seventh post-operative day. All the other patients are alive and well. Morbidity was very low. In each of five cases of fecal fistula healing occurred spontaneously, the longest delay being 34 days. In four cases of electrolyte imbalance this was rapidly rectified. No patient is truly incontinent. The procedure, however, is long and difficult, and requires meticulous attention to all details.

Proliferative Mucosal Lesions Associated with Vesical Neoplasms.

R. B. EISENBERG *et alii* (*J. Urol. (Baltimore)*, October, 1960) present a study of proliferative lesions of the mucosa which occur near definite vesical tumours and which may be of importance in the genesis of subsequent neoplasms. For the purpose of this study the following classification of proliferative lesions is adopted: (i) Cystitis cystica and cystitis glandularis, characterized by inflammation and downward proliferation of the surface epithelium forming nests and glands in the submucosa; further development results in secretion of mucus and dilatation of the gland spaces; cellular atypism is not present. (ii) Atypical hyperplasia, characterized by alteration of cells and pattern of the surface epithelium; dark-staining nuclei and occasional mitotic figures are seen; there is loss of orderly cell arrangement, with some clumping of cells. (iii) Papillary hyperplasia, which is similar to (ii), but shows a tendency to produce broad processes protruding into the bladder. (iv) Intraepithelial epithelioma (carcinoma-in-situ), characterized by cellular atypism and alteration of pattern to a marked degree; the nuclei are large, irregular and intensely basophilic; the scanty cytoplasm is pale and granular; mitotic figures are common. (v) Overt neoplasms, such as papillomas, transitional cell epitheliomas, squamous cell carcinomas and adenocarcinomas. This study is based on 171 consecutive biopsies. The specimens were classified as follows: papilloma, 2; transitional cell papillary epithelioma, 111; transitional cell infiltrating epithelioma, 50; squamous cell epithelioma, 2; adenocarcinoma, 1; unclassified fragments, 5. The authors state that it is important that the surgeon should provide the pathologist with enough mucosa around the growth to allow a proper search for mucosal lesions. In this series, proliferative lesions of some kind were found in the neighbouring mucosa in 32% of cases of papillary tumours and in 30% of infiltrating tumours. Clinical correlations in a rigidly selected, fully followed group of 24 cases showed that in no case in which wholly satisfactory progress was recorded for five years or more were such lesions initially present. In all cases in which progress after operation was unsatisfactory such lesions have previously been demonstrated.

British Medical Association.

VICTORIAN BRANCH: ANNUAL MEETING

The annual meeting of the Victorian Branch of the British Medical Association and the Medical Society of Victoria was held on December 7, 1960, at the Medical Society Hall, 426 Albert Street, East Melbourne. Dr. H. G. JUDKINS, the President, in the chair.

MINUTES.

The minutes of the annual meeting held on December 2, 1959, were confirmed.

ELECTION OF OFFICE-BEARERS.

The Medical Society announced that the Council had elected the following office-bearers for 1961:

President: Dr. G. Newman-Morris.

Vice-Presidents: Dr. Stanley Williams and Dr. Mervyn Robinson.

Honorary Secretary: Dr. A. M. Hutson.

Honorary Treasurer: Dr. L. H. Ball.

Honorary Librarian: Dr. Bryan Gandevia.

Chairman of Council: Dr. H. C. Colville.

The Medical Secretary announced that the following had been elected members of the Council by the general body of members: Dr. K. Brennan, Dr. D. Donald, Dr. J. L. Frew, Dr. H. G. Furnell, Dr. K. H. Hallam, Dr. A. M. Hutson, Dr. W. E. E. Langford, Dr. R. S. Lawson, Dr. W. E. I. Littlejohn, Dr. D. G. Mackellar, Dr. A. B. McCutcheon, Dr. G. Newman-Morris, Professor S. Sunderland, Dr. S. W. Williams.

The Medical Secretary announced that the following had been elected members of the Council by the subdivisions: Dr. L. Ball, Dr. A. J. M. Sinclair, Dr. T. G. Swinburne, Dr. N. L. Dodd, Dr. K. E. Ratten, Dr. H. G. Judkins, Dr. F. Bishop, Dr. H. F. Tucker, Dr. J. Gavin Johnson, Dr. J. Best, Dr. C. M. Roseby, Dr. J. F. Akeroyd, Dr. E. Sandner, Dr. V. D. Pleueckhahn, Dr. M. H. Robinson, Dr. D. F. Mitchell, Dr. W. R. Angus, Dr. B. Hutton-Jones, Dr. F. R. Phillips, Dr. D. F. Lally.

The Medical Secretary announced that the ex-officio members of the Council were as follows: Dr. H. C. Colville, Dr. F. L. Davies, Dr. D. Roseby, Dr. R. Southby, Dr. G. R. Weigall, Dr. J. P. Major. The representative of the Victorian Medical Women's Society was Dr. Alison Wright.

The Medical Secretary announced that Dr. Bryan Gandevia had been coopted to the Council.

ANNUAL REPORT OF THE COUNCIL.

The annual report of the Council, which had been circulated among members, was received and adopted. The report is as follows.

The Council of the Branch and the Committee of the Society present the eighty-first annual report of the Branch and the one hundred and fifth of the Society.

Election.

At the annual meeting held last December, the following members of the Council and of the Committee were elected, following a ballot of members of the Branch: Dr. Kevin Brennan, Dr. Douglas Donald, Dr. J. L. Frew, Dr. H. G. Furnell, Dr. Keith H. Hallam, Dr. A. M. Hutson, Dr. W. E. King, Dr. W. E. E. Langford, Dr. Robert S. Lawson, Dr. A. B. McCutcheon, Dr. D. G. McKellar, Dr. G. Newman-Morris, Dr. B. K. Rank, Dr. Stanley Williams.

The following were elected to represent the subdivisions: Dr. J. F. Akeroyd, Dr. W. R. Angus, Dr. Leonard Ball, Dr. A. W. Burton, Dr. N. L. Dodd, Dr. W. E. Hewitt, Dr. B. Hutton-Jones, Dr. J. Gavin Johnson, Dr. H. G. Judkins, Dr. D. F. Lally, Dr. D. F. Mitchell, Dr. F. R. Phillips, Dr. V. D. Pleueckhahn, Dr. K. E. Ratten, Dr. M. H. Robinson, Dr. Charles M. Roseby, Dr. E. Sandner, Dr. A. J. M. Sinclair, Dr. T. G. Swinburne, Dr. H. F. Tucker. Following the retirement from Council in May of Dr. Burton on his taking up the appointment of Deputy Medical Secretary of the Branch, Dr. James Best was elected to represent the South-Eastern Suburban Subdivision.

Under Rule 9 of the Branch, Council elected Dr. Alison Wright who was nominated by the Victorian Medical Women's Society.

The following are ex-officio members: The trustees of the Medical Society of Victoria, Dr. H. C. Colville, Dr. F. L. Davies, Dr. D. Roseby, Dr. Robert Southby and Dr. G. R. Weigall; and the Director for Victoria of the Australasian Medical Publishing Company, Dr. J. P. Major.

Coopted members: Major-General W. D. Refshauge, Professor S. Sunderland, and Dr. Bryan Gandevia. Major-General Refshauge resigned during the year following his retirement from the office of Director-General of Medical Services (Army) on appointment as Director-General, Commonwealth Department of Health.

The Council elected the following office-bearers:

President: Dr. H. G. Judkins.

Vice-Presidents: Dr. G. Newman-Morris and Dr. Stanley Williams.

Chairman of Council: Dr. H. C. Colville.

Honorary Treasurer: Dr. Leonard Ball.

Honorary Librarian: Dr. A. M. Hutson, Dr. Bryan Gandevia.

Honorary Secretary: Dr. A. W. Burton, Dr. A. M. Hutson.

Dr. A. M. Hutson was appointed Honorary Secretary following Dr. Burton's retirement from Council, and Dr. Bryan Gandevia was appointed Honorary Librarian to fill the vacancy thus created.

The Executive consisted of the President, the Immediate Past President (Dr. J. Gavin Johnson) and the other office-bearers.

Attendances at Council Meetings.

Fourteen meetings of the Branch Council were held during the year, the following showing the attendances:

Dr. H. C. Colville	14	Dr. G. R. Raleigh Weigall	11
Dr. F. L. Davies	14	Dr. D. F. Mitchell	10
Dr. H. G. Judkins	14	Dr. Stanley Williams	10
Dr. Robert Southby	14	Dr. W. E. Hewitt	10
Dr. H. F. Tucker	14	Dr. Kevin Brennan	9
Dr. J. F. Akeroyd	13	Dr. A. B. McCutcheon	9
Dr. J. Gavin Johnson	13	Dr. J. P. Major	9
Dr. Robert S. Lawson	13	Dr. M. H. Robinson	9
Dr. G. Newman-Morris	13	Dr. A. J. M. Sinclair	9
Dr. V. D. Pleueckhahn	13	Dr. W. E. King	8
Dr. D. Roseby	13	Dr. D. F. Lally	8
Dr. T. G. Swinburne	13	Dr. A. W. Burton	7 ²
Dr. D. Donald	13	Dr. B. K. Rank	7
Dr. N. L. Dodd	12	Dr. D. G. MacKellar	6
Dr. J. L. Frew	12	Dr. W. R. Angus	6
Dr. A. M. Hutson	12	Dr. James Best	4 ³
Dr. K. E. Ratten	12	Dr. W. E. E. Langford	4 ¹
Dr. Charles M. Roseby	12	Dr. F. R. Phillips	4
Dr. Alison Wright	12	Dr. B. Hutton-Jones	3
Dr. Leonard Ball	11	Maj.-Gen. W. D. Ref-	
Dr. H. G. Furnell	11 ¹	shage	2 ²
Dr. Keith H. Hallam	11	Prof. S. Sunderland	1 ²
Dr. E. Sandner	11	Dr. B. Gandevia	1 ²

Dr. M. Clark, Dr. K. C. Porter and Dr. B. S. Alderson each attended one meeting as proxy for Dr. E. Sandner, Dr. M. H. Robinson and Dr. W. R. Angus.

The highest attendance at any one meeting was 38, and the average was 31.

Subcommittees of the Branch Council.

The first-named is the Convenor.

Complaints: Dr. Davies, Dr. Johnson, Dr. McCutcheon, Dr. Newman-Morris and Dr. D. Roseby.

Correspondence: Dr. Colville and Dr. Hutson.

Ethics: Dr. Davies, Dr. King, Dr. Major, Dr. D. Roseby, Dr. Southby, Dr. Swinburne, Dr. Weigall and the Executive.

Finance, House and Library: Dr. Ball, Dr. Furnell, Dr. Johnson and Dr. Tucker.

Hospital: Dr. Southby, Dr. Akeroyd, Dr. Ball, Dr. Brennan, Dr. Colville, Dr. Dodd, Dr. Donald, Dr. Frew, Dr. Hallam, Dr. King, Dr. Lawson, Dr. Rank, Dr. Weigall, Dr. Williams and Dr. Wright.

Information Service: Dr. Rank, Dr. Brennan, Dr. Newman-Morris, Dr. Phillips and Dr. Ratten.

Legislation: Dr. Colville, Dr. Davies, Dr. Hallam, Dr. Rank and Dr. Sinclair.

Organization: Dr. Swinburne, Dr. Akeroyd, Dr. Ball, Dr. Best, Dr. Brennan, Dr. Colville, Dr. Dodd, Dr. Frew, Dr. Furnell, Dr. Johnson, Dr. McCutcheon, Dr. Ratten, Dr. Roseby, Dr. D. Roseby, Dr. Sinclair, Dr. Southby, Dr. Tucker, Dr. Wright and representatives of the country subdivisions.

Science: Dr. Hallam, Dr. Furnell, Dr. King, Dr. Lawson and Dr. Williams.

Health Education: Dr. D. Roseby, Dr. Brennan, Dr. Rank and Dr. Wright.

¹ Granted leave of absence during the year.

² Resigned during the year.

³ Appointed during the year.

Social: Dr. D. Roseby, Dr. Best, Dr. Tucker and Dr. Weigall.

Workers' Compensation: Dr. Newman-Morris, Dr. Colville, Dr. Dodd, Dr. Donald, Dr. Rank, Dr. Ratten and Dr. D. Roseby.

Special Committees and Offices within the Branch.

B.M.A. 103rd Annual General Meeting, Prize Committee: Dr. J. P. Major, Dr. Ewen Downie, Professor E. S. J. King, Dr. G. R. Weigall and Dr. G. R. A. Syme.

Federal Medical War Relief Fund, Advisory Committee: Dr. F. L. Davies, Dr. H. G. Furnell and Sir William Upjohn.

Joint Committee with Health Department re Spheres of Responsibility for Medical Services to the Community: The President, Dr. Newman-Morris, Dr. A. J. M. Sinclair, Professor V. L. Collins and Dr. George Swinburne.

Library Advisory Committee: Dr. B. Gandevia (Honorary Librarian), Dr. J. H. W. Birrell, Dr. F. M. C. Forster, Dr. T. A. F. Heale, Dr. R. S. Lawson, Dr. Murray Maxwell and Dr. M. L. Verso.

Medical Officers' Relief Fund (Federal) Advisory Committee: Dr. F. L. Davies, Dr. H. G. Furnell and Sir William Upjohn.

Medical Society of Victoria, Trustees of: Dr. H. C. Colville, Dr. F. L. Davies, Dr. D. Roseby, Dr. Robert Southby and Dr. G. Raleigh Weigall.

Museum Advisory Committee: The Curator (Dr. B. Gandevia), Dr. J. H. W. Birrell and Dr. M. L. Verso.

Services Recognition Fund, Trustees of: Sir Albert Coates, Dr. H. G. Furnell and Major-General Sir Kingsley Norris.

World Medical Association Supporting Committee: Dr. D. Roseby, Dr. K. H. Hallam, Dr. B. K. Rank, Dr. A. J. M. Sinclair and Dr. Stanley Williams.

Appointments and Nominations.

Alcoholism Foundation of Victoria: Dr. L. H. Ball.

Anti-Cancer Council of Victoria: Dr. J. E. Clarke and Dr. H. Searby.

Anti-Cancer Council, Medical and Scientific Committee of: Professor Maurice Ewing.

British Medical Association, Annual Representative Meeting, Torquay, 1960: Professor Vernon Collins, Dr. John Hayward.

British Medical Association, Central Council: Dr. M. L. Formby.

British Medical Association in Australia, Federal Council: Dr. H. C. Colville, Dr. J. G. Johnson and Dr. George Swinburne.

British Medical Agency of Victoria, Pty. Ltd., Directors: Dr. C. H. Dickson (Chairman), Dr. Leonard Ball, Major-General Sir Kingsley Norris, Dr. Robert Southby and Dr. A. W. Burton.

British Medical Insurance Company of Victoria, Ltd., Directors: Sir William Johnston (Chairman), Dr. C. H. Dickson, Dr. H. G. Furnell, Major-General Sir Kingsley Norris and Dr. G. Newman-Morris.

Central Medical Library Committee: Dr. Bryan Gandevia.

Consultative Council on Influenza: Professor J. G. Hayden.

Consultative Council on Maternal Mortality: Dr. J. G. Johnson.

Consultative Council on Poliomyelitis: Sir William Upjohn.

Consultative Council on Quarantineable Diseases: Dr. P. Gilbert.

Dietetic Association of Victoria: Dr. T. A. F. Heale.

Filled Milk, Advisory Committee re: Professor V. L. Collins.

Fluoridation of Public Water Supplies, Citizens' Committee for the Promotion of: Dr. Stanley W. Williams.

Hæmophilia Society: Dr. R. J. Sawers.

Health (Proprietary Medicines) Act, Advisory Committee under the Provisions of: Dr. Byron L. Stanton.

Hospital Benefits Association of Victoria: Dr. C. H. Dickson, Major-General Sir Kingsley Norris, Dr. H. G. Judkins and Dr. G. R. Weigall.

Hospitals and Charities Commission, Advisory Council to: Dr. L. H. Ball and Dr. C. H. Dickson.

Medical Salaries, Advisory Committee re: Professor V. L. Collins, Dr. G. Newman-Morris and Dr. George Swinburne. (Dr. J. L. Frew acted while Professor Collins was absent abroad.)

Joint Insurance Adjudication Committee: Dr. L. H. Ball, Dr. D. Roseby and Sir William Upjohn.

Lord Mayor's Fund: Dr. A. B. McCutcheon.

Lord Mayor's Country Children's Holiday Camp, Committee of: Dr. Gwynne Villiers.

Masscours' Registration Board: Dr. Bryan Keon-Cohen and Dr. Leigh T. Wedlick.

Medical Eye Service of Victoria: Dr. E. N. Rosen.

The Medical Journal of Australia, Victorian Correspondent: Dr. C. H. Dickson.

Medical Society Trust Company Ltd., Directors: Dr. Leonard Ball, Dr. H. C. Colville, Dr. J. G. Johnson, Dr. K. H. Hallam, Dr. H. G. Judkins, Dr. A. B. McCutcheon, Dr. K. E. Ratten and Professor V. L. Collins.

Medico-Pharmaceutical Liaison Committee: Dr. W. E. King, Dr. D. Roseby, Dr. Byron Stanton, the President (*ex officio*) and the Medical Secretary.

Melbourne Medical Post-Graduate Committee: Dr. F. R. Phillips and Dr. G. R. Weigall.

Museum of the Medical Society of Victoria, Curator: Dr. Bryan Gandevia.

National Committee of British Commonwealth Collection of Micro-Organisms: Professor S. D. Rubbo.

National Heart Foundation: Dr. J. L. Frew.

National Safety Council of Australia: Dr. Kevin Brennan.

Nursing Aide School, Committee of Management: Dr. W. D. L. Farrar.

The Occupational Therapy School of Victoria: Dr. D. O. Longmuir.

Old People's Welfare Council: Dr. A. B. McCutcheon and Sir William Johnston.

Opticians' Registration Board: Dr. R. Collmann and Dr. R. F. Lowe.

Pensioner Medical Service, Committee of Inquiry: Professor J. F. Hayden, Dr. C. Byrne, Dr. J. G. Johnson and Dr. M. O. Kent-Hughes.

Rehabilitation Medical Advisory Committee, Victoria (Social Services Department): Dr. J. Cuming Stewart.

Rotary Club (Citizens' Committee): The President of the Branch.

Royal Flying Doctor Service of Australia: Dr. George Simpson.

Standing Committee of Medical Clerical Conferences: Dr. A. Murray Clarke, Dr. Arthur J. Day, Dr. J. G. Johnson, Dr. H. G. Judkins, Dr. R. Southby and Professor Lance Townsend.

State Medical Planning Committee: Dr. H. G. Furnell.

Student Health Service, Advisory Committee to University: Dr. J. L. Frew.

Tetanus Prevention, Committee on: Dr. T. H. Ackland.

Victorian Baby Health Centres' Association: Dr. Stanley Williams.

Victorian Bush Nursing Association: Dr. E. McComas.

Victorian Council of Speech Therapy: Dr. Robert Southby.

Victorian Documentary Film Council, Advisory Committee on Scientific Films: Dr. Morris Davis and Dr. R. S. Hooper.

Victorian Health Week Committee: Dr. D. Roseby.

Victorian Nursing Council: Dr. J. L. Frew and Professor Lance Townsend.

Victorian Society for Crippled Children: Dr. John Cloke.

Branch Convocation.

The following were elected for the year 1960. **Melbourne Central:** Dr. C. J. O. Brown, Dr. C. H. Fitts, Dr. T. J. F. Frank, Dr. Peter Freeman, Dr. H. Boyd Graham, Dr. N. T. Hamilton, Dr. T. A. F. Heale, Dr. Tom Hurley, Dr. Anthony Kelly, Dr. Graham McKenzie, Dr. Ian McVey, Dr. G. A. Penington, Dr. H. A. Phillips, Dr. S. Reid, Dr. C. A. M. Renou, Dr. J. E. Sewell, Dr. J. G. Shelton, Dr. Norman L. Speirs, Dr. G. Springthorpe, Dr. Elizabeth Turner, Dr. C. S. Wood. **Eastern Suburban:** Dr. P. M. Birrell, Dr. W. L. Carrington, Dr. W. Austin Cooper, Dr. A. Feddersen, Dr. H. V. Francis, Dr. A. L. Hare, Dr. H. H. Jackson, Dr. C. Lancaster, Dr. J. G. McMahon, Dr. R. G. Penington, Dr. N. McH. Ramsey, Dr. R. D. Rush, Dr. J. G. Simpson, Dr. T. Stokoe. **Southern Suburban:** Dr. J. H. Body, Dr. D. L. Collie, Dr. T. W. O. Farrell, Dr. G. A. Guthrie, Dr. H. Hoban, Dr. A. Ley, Dr. R. S. Smibert. **Western Suburban:** Dr. B. H. E. Barracough, Dr. D. D. Coutts, Dr. A. H. Green, Dr. J. A. Keipert, Dr. G. O. Phillips. **South East Suburban:** Dr. J. F. Adamson, Dr. James Best, Dr. M. Bunn, Dr. R. D. Bunting, Dr. J. V. C. de Crespiigny, Dr. C. C. Dyte, Dr. M. J. Lindsey, Dr. N. H. Luth, Dr. J. E. McCarthy, Dr. T. R. Thomson. **North Eastern Suburban:** Dr. E. S. Esnouf, Dr. L. J. Hartman, Dr. W. P. Heslop, Dr. S. D. Mecoles.

Northern Suburban: Dr. F. A. L. Bacon, Dr. D. C. Corderer, Dr. J. E. Dunn, Dr. E. C. Gawthorn, Dr. R. Gurry, Dr. D. C. Lear, Dr. H. R. Walker, Dr. I. A. Wilson, Dr. I. D. Wilson. *South Central*: Dr. D. J. M. Dunn, Dr. E. A. C. Farran, Dr. L. W. Knight, Dr. J. Smibert, Dr. Q. Whitehead, Dr. C. W. Wilson. *Maroondah*: Dr. J. McCubbin, Dr. P. Matthews, Dr. W. M. G. Leembrugge. *Peninsula*: Dr. C. Hopkins, Dr. H. M. Stevenson, Dr. J. Williams. *Bellarat*: Dr. G. R. Davidson, Dr. K. J. Neerhut, Dr. D. B. Skewes. *Bendigo*: Dr. N. N. Harrington, Dr. W. J. Long, Dr. A. L. Newson, Dr. W. Rosenthal. *Gippsland*: Dr. J. M. Andrew, Dr. W. G. Birks, Dr. A. A. Crook, Dr. W. F. Ferguson. *North Eastern Country*: Dr. K. J. Lipsut, Dr. D. M. Whittaker. *South-Western Country*: Dr. A. E. Brauer, Dr. S. C. Fitzpatrick, Dr. B. D. Vaughan. *Geelong*: Dr. G. C. Darby, Dr. E. I. Fargie, Dr. H. R. Millikan. *Goulburn*: Dr. A. E. Dickman, Dr. R. O. Mills. *North-Western Country*: Dr. A. A. Hinckley, Dr. T. V. Walpole, Dr. Ross W. Webster.

Membership Roll.

The number of members on the roll at October 21, 1960, was 3295, which was 90 more than last year. Three hundred and eight names were added (138 by election, 59 were reinstated on payment of arrears, and 111 were transferred from other States and overseas); and 218 were removed (31 by death, 96 by transfer, 12 by resignation, and 79 allowed their subscriptions to fall into arrears).

Honorary medical members number 39, and there is one complimentary member.

Honorary student associates number 42.

Deceased.

The deaths of the following members and former members occurred during the year and are recorded with regret:

Dr. C. H. B. Adamson, Dr. M. N. Allen, Dr. Stella Altmann, Dr. S. Baltrunas, Dr. W. Begg, Dr. C. B. Berryman, Dr. M. Bloch, Dr. A. W. Bowman, Dr. N. E. H. Box, Dr. R. C. E. Brodie, Dr. Sir Samuel Burston, Dr. R. M. F. Cameron, Dr. D. J. C. Crotty, Dr. E. G. Dahlenburg, Dr. N. R. Dale, Dr. C. E. Dennis, Dr. H. F. H. Elvins, Dr. G. G. Godfrey, Dr. W. H. Hinrichsen, Dr. R. J. A. Henderson, Dr. W. C. Holding, Dr. H. I. Holmes, Dr. R. A. Howett, Dr. A. H. Hughes, Dr. C. W. B. Littlejohn, Dr. A. J. Macdonald, Dr. C. F. MacGillicuddy, Dr. J. K. D. Mackenzie, Dr. K. A. McLean, Dr. R. B. Maynard, Dr. M. F. Meyer, Dr. E. D. Milliken, Dr. L. A. Neal, Dr. T. V. Nihill, Dr. M. G. Regan, Dr. C. W. G. Roche, Dr. O. Richlon, Dr. D. B. Rosenthal, Dr. J. A. Scott, Dr. J. N. Shelton, Dr. P. R. Slater, Dr. N. Lennox Speirs, Dr. Kathleen True, Dr. F. T. Wheatland, Dr. B. Rosse Woods.

Remembrance Day.

A short ceremony, attended by members of the Branch and relatives of deceased medical officers of the Armed Forces, was held in the foyer of the Medical Society Hall on Friday, November 11, 1960, to honour the Victorian medical officers who lost their lives while on active service in the two world wars of this century. After the Medical Secretary had read the names of those killed on service and of those who had died while serving, the President laid a wreath on the War Memorial.

Annual Church Services.

The eleventh annual church services for the medical profession were held in St. Paul's and St. Patrick's Cathedrals on Sunday, February 28, 1960. Members and their families and medical students attended the services. Members and medical students formed processions to enter the cathedrals.

At St. Paul's Cathedral the sermon was preached by the Archbishop, the Most Reverend Frank Woods, M.A., D.D., and the lessons were read by the President, Dr. H. G. Judkins, and the Vice-President, Mr. Geoffrey Newman-Morris.

At St. Patrick's Cathedral the sermon was preached by the Administrator of the Cathedral, the Very Reverend L. P. Moran.

Congratulations.

During 1960 the Branch Council had pleasure in congratulating the following:

Professor Sir Edward Ford, O.B.E. (N.S.W.), Sir William Johnston, C.B.E., D.S.O., M.C., E.D., and Sir Douglas Robb, C.M.G. (N.Z.), on being created Knights Bachelor; Sir Charles Bickerton Blackburn, K.C.M.G., O.B.E. (N.S.W.), Colonel R. G. Champion de Crespigny, O.B.E. (S.A.), Dr. J. R. Donaldson, O.B.E. (W.A.), Dr. Henry McLorinan, C.B.E., Dr. W. Barbara Meredith, O.B.E., Dr. T. J. O'Leary, C.B.E. (Q.), and Colonel J. G. G. White, C.B.E., as the recipients of honours from Her Majesty the Queen; Dame

Mary Herring on being created a Dame of the British Empire; Sir William Upjohn, O.B.E., on being appointed President of the Royal Melbourne Hospital; Dr. R. R. Andrew on being appointed Dean of the Medical School, Monash University; Dr. Elizabeth Wilmet on being appointed Director of the Maternal, Infant and Pre-School Welfare Branch of the Health Department; Major-General W. D. Refshauge on his appointment as Director-General of Health for the Commonwealth; Major-General A. J. Clyne on being appointed Director-General of Medical Services (Army); and Dr. R. S. A. Marshman on his appointment as Director of Tuberculosis, Department of Health (Victoria).

The Branch Council takes pride in the award of the Nobel Prize in Medicine for 1960 to Sir Macfarlane Burnet, O.M. This is the first time that the award has been made to an Australian for original work in Australia, and in conveying its congratulations the Branch Council felt that it expressed the pleasure of all his fellow-members.

Golf.

The twenty-first annual golf tournament of the Branch was held on Thursday, November 26, 1959, on the West Course of the Royal Melbourne Golf Club. Dr. J. R. Sherwin won the Weigall Cup (Championship), and the Roseby Cup (Handicap) was won by Dr. J. R. Searls. The Spoon Competition was won by Dr. G. W. Briggs and Dr. K. Coleman.

Entertainment.

The 1959 new graduates were welcomed into the profession by the President and members of Council at morning tea on Monday, December 21, 1959.

At a late afternoon party on Friday, December 4, 1959, His Excellency the Governor of Victoria presented the portrait of Dr. Henry Cecil Colville by Mr. William Dargie to the Medical Society of Victoria. The portrait now hangs in the Council Chamber beside that of Crawford Henry Mollison.

On Saturday, February 27, while the Federal Council was meeting in Melbourne, the Branch Council gave a dinner at Union House in honour of Sir William Johnston and for Federal Council members.

On Thursday, May 26, a small informal late afternoon party was held at which the Honourable Ewen Cameron, M.L.C., Minister of Health, was presented with a cheque from a bequest controlled by the Committee of the Medical Society of Victoria for use by medical officers of the School Medical Service.

Meetings of the Branch.

The following meetings of the Branch were held in Melbourne:

March: Dr. C. J. Officer Brown gave an illustrated talk on a recent visit to Borneo and New Guinea.

April: (i) "The Management of Common Fractures and Joint Injuries in General Practice" was discussed by Mr. Kingsley W. Mills, Mr. Bryan Keon-Cohen and Mr. John Cloke. (ii) A panel discussion on "Control of Infection in Hospitals" was arranged by the Bacteriology Department, University of Melbourne. Professor S. D. Rubbo was the chairman, and the other speakers were members of the research team that assisted in a recent investigation conducted in public hospitals.

June: The tenth Embley Memorial Lecture, entitled "The Embley Tradition—Experimentation in Anaesthesia", was delivered by Professor F. H. Shaw, Ph.D., M.Sc.

July: A symposium on "Toxaemias of Pregnancy" was arranged by the Victorian State Committee of the Royal College of Obstetricians and Gynaecologists, the following being the subjects and speakers: "Recent Concepts on the Aetiology of the Toxaemias of Pregnancy", Dr. Eric Mackay; "The Prevention of Toxaemia of Pregnancy", Dr. Noel De Garis; "The Treatment of Toxaemia of Pregnancy", Miss M. A. Mackie; "The Results of Treatment", Professor Lance Townsend.

August: "Radiation Hazards" was discussed by Mr. D. J. Stevens, Director of the Commonwealth X-Ray and Radium Laboratory, and Dr. H. A. S. van den Brenk, of the Cancer Institute Board Radiobiological Research Unit.

October: The twenty-seventh Sir Richard Stawell Oration, entitled "Infectious Enthusiasm", was delivered by Sir William Upjohn.

November: Dr. Roderick Strang gave an illustrated talk entitled "Rheumatism Revisited".

The following demonstrations and clinical meetings were held in Melbourne:

May: Queen Victoria Memorial Hospital.

July: Alfred Hospital.

October: The Royal Children's Hospital.

The following meetings were held in the country:

May: Hamilton—A clinical meeting was held in the afternoon at the Glenelg Base Hospital. In the evening Dr. A. A. Bartholomew, Psychiatrist-in-Charge of the Psychiatric Clinic, Penridge, and the Alexandra Clinic, spoke on "Psychiatry in a Penal Setting".

August: Traralgon—Clinical cases were presented at the Traralgon District Hospital in the afternoon, and in the evening Mr. Thomas J. Thwaite of Morwell spoke on "Crohn's Disease".

October: Ballarat—In the afternoon a clinical meeting was held at the Ballarat and District Base Hospital and in the evening Dr. Clive H. Fitts gave an address entitled "The Solitary Reaper".

The Branch Council wishes to express its appreciation and thanks to the committees and honorary secretaries of country subdivisions for arranging the country meetings, to the wives of members of the subdivisions for their hospitality to visiting members and their wives; and to the committees and matrons of the Glenelg, Traralgon and Ballarat Base Hospitals for the facilities provided.

The Council also thanks the staffs of the Bacteriology Department, and of the Queen Victoria Memorial Hospital, the Alfred Hospital and the Royal Children's Hospital for arranging meetings.

The following special meetings of the Branch were held during the year: (i) In May a special meeting was called, under the provisions of Rule 29, on the requisition of 49 members, in order to discuss the report of the Medical Salaries Committee. (This matter is referred to under the heading "Branch and Council Activities".) (ii) In November a special meeting was called by the Branch Council to place before the general body of members the proposal that membership subscriptions be increased.

Council Activities.

Formation of an Australian Medical Association.

A meeting of Branch Convocation endorsed the proposal that an Australian Medical Association should be formed, and a "steering committee" appointed by the Federal Council has drawn up a draft constitution for the new Association. The suggested constitution will be considered by a Convention, representative of all sections of the profession in Australia, to be held in Sydney in November, and the constitution as finally determined will be submitted to a further meeting of the Branch Convocation for ratification.

Branch Organization.

1. *Deputy Medical Secretary:* Dr. A. W. Burton commenced duty as Deputy Medical Secretary on July 1, 1960.

2. *Office Accommodation:* Plans are proceeding to obtain vacant possession of properties owned by the Medical Society of Victoria in Lansdowne Street, and in 1961 they will be converted to professional rooms and a new library constructed on the first floor. The existing library at 426 Albert Street will then be reconstructed to give additional office space.

3. *Organization of the Profession:* The Organization Subcommittee initiated plans during the year to enable the Branch Council to obtain rapidly and accurately the opinion of members on proposals which may affect the future of medical practice, and on any other matters. The details of the plan were explained to a meeting of subdivisional office-bearers and the plans are now being developed.

National Health Service.

Although it is the function of the Federal Council to conduct with the Commonwealth Government negotiations affecting the National Health Service, and reports of Federal Council meetings are published in *THE MEDICAL JOURNAL OF AUSTRALIA*, the following matters of general interest that occurred during the year are reported for the information of members of the Branch:

1. *Pharmaceutical Benefits:* On March 1, 1960, the system under which life-saving and disease-preventing drugs were available free to the community as Pharmaceutical Benefits was changed and a charge of 5s. per prescription imposed. At the same time most of the benefits which had been available to pensioners became available to the general public on payment of a 5s. fee. Despite representations from the Federal Council that the introduction of the scheme should be delayed to enable the profession to examine its implications, it came into operation on March 1. As doctors in practice became aware of the imperfections and disadvantages of the new arrangement, widespread dissatisfaction was expressed throughout Australia, and in Victoria subdivisional meetings almost without exception condemned many facets of the scheme. Some modification of the benefits available and the conditions under which they may be prescribed will come into operation on November 1, but at the time of writing details are not available.

2. *Pensioner Medical Service:* (i) *Conditions of Service.*—Under the *National Health Act* the conditions of service in the Pensioner Medical Service are governed by an agreement between the Minister for Health and the Federal Council, but individual doctors work under an agreement between themselves and the Director-General of Health. The agreement with the Federal Council expired on June 30, 1960, and the Federal Council is seeking an increase in the fees payable, the correspondence in relation to those negotiations being published in full in the *Monthly Paper* for October. Meanwhile, the individual agreements of doctors remain in force. (ii) *Pensioners in Public Beds.*—A participant in the Pensioner Medical Service is not entitled to claim a fee for services to pensioners occupying public beds in public hospitals, and during the year it was learned that the Hospitals and Charities Commission had declared certain portions of some benevolent homes to be "public hospitals" within the definition of the *Hospital and Charities Act*, to enable hospital benefits to be claimed in relation to those beds. The Commonwealth Health Department then decided that a participating doctor could not claim fees for his services to patients occupying those beds, but following representations on the matter that decision has been abandoned.

State Legislation.

1. *Cremation:* It was mentioned in the annual report for 1959 that amending legislation imposing additional safeguards in relation to the disposal of bodies by cremation would come into force this year. The operation of the new arrangements has, however, been delayed and probably will not operate before 1961.

2. *Amendments to the Medical Act:* (a) During the year a short amendment was made to the *Medical Act* extending for one year the time during which holders of foreign qualifications could seek registration after examination by a special body appointed for the purpose. (b) A bill is at present before Parliament authorizing two doctors under specified conditions to carry out blood transfusions on a child under the age of 16 years when such is considered necessary to preserve the life of that child and parental consent cannot be obtained or is refused.

Medical Education.

Evidence was given to the Committee on Medical Undergraduate Education in Victoria appointed by the Government of Victoria, and it was gratifying to learn when the report of that Committee was published that many of the views advanced by the representatives of the Branch Council had been supported.

Fees.

1. *General Practice:* Following the procedure adopted in 1955, advice was again sought from expert statisticians regarding changes in overhead costs and other factors, and following their report the Branch Council recommended to members that fees in general practice should be increased as from January 1, 1960.

2. *Workers' Compensation:* Negotiations were conducted during the year with the Fire and Accident Underwriters Association of Victoria for an increase in the "visit fees" under the agreement which has operated since January 1, 1958. Representations that the schedule of fees should apply only to "traumatic" cases and not to the many "medical" cases now being accepted as compensable were rejected by the underwriters, but the schedule of "visit fees" will shortly be increased.

3. *Witness Fees:* Arrangements are being made for a deputation to the Attorney-General, representative of all the professional bodies concerned, which will request an increase in fees payable to professional witnesses.

Medical Salaries Committee.

On publication of the report of the Committee whose recommendations regarding salaries payable to medical officers of all grades employed in public hospitals were accepted by the Hospitals and Charities Commission, dissatisfaction with many of the recommendations was widely expressed. The matter was discussed at a special meeting of the Branch and, subsequently, representatives of all the interests affected by the recommendations of the Committee met and later waited on the Minister of Health to express their views. Since then the Branch Council has requested on behalf of those affected that they be given

an opportunity of presenting further evidence to the Committee.

Car Badges.

An attractive badge for attachment to doctors' cars has been designed and will shortly be available to members. These badges will not grant any privileges, but it is anticipated that their display will identify cars parked in the vicinity of hospitals and other premises where patients are attended.

Formation of New Sections.

During the year approval was given by Council to the formation of two new sections, the Geriatric Group and the Association of Salaried Medical Specialists.

Many other matters have been dealt with by both the Branch Council and the Executive in addition to the above. A great deal of business referred to, and arising from, the activities of the Federal Council, has not been recorded here, as full reports of the meetings of the Federal Council appear in *THE MEDICAL JOURNAL OF AUSTRALIA*.

Federal Council.

Two ordinary meetings of the Federal Council were held during 1960, one being held in Melbourne in February and the other in Adelaide in August. Full reports of the proceedings of these meetings have been published in *THE MEDICAL JOURNAL OF AUSTRALIA* (March 26 and September 3 issues). A special meeting, called for November 25, immediately preceding the Convention to consider the draft constitution of the Australian Medical Association, had not taken place at the time of the writing of this report.

The Library of the Medical Society of Victoria.

The personnel of the Library Advisory Committee remains the same, except for Professor V. L. Collins, who resigned in February. Members are: Dr. B. Gandevia, Dr. J. H. W. Birrell, Dr. F. M. C. Forster, Dr. T. A. F. Heale, Dr. R. S. Lawson, Dr. M. Maxwell, Dr. M. Verso.

During the year there have been two changes of Honorary Librarian, the holder of that office being also Chairman of the Committee. Professor Collins resigned because of pressure of work and an overseas tour. He was succeeded by Dr. A. M. Hutson, who also resigned following his appointment as Honorary Secretary to the Branch in August. Dr. Bryan Gandevia was then appointed.

With the exception of January, meetings have been held each month, when new purchases have been considered and the review of the older section of the library continued. Books removed from the shelves have been placed either in the Museum or disposed of after consultation with the Central Medical Library Organization.

The important task of recataloguing the library and building up a subject catalogue continues under the guidance of Dr. M. Maxwell.

The following additions were made to the library: 76 new books were purchased and 43 donated by *THE MEDICAL JOURNAL OF AUSTRALIA*, making a total of 138. The library is indebted to the Australian Fellowship of the Israel Medical Association for a subscription to the *Bulletin of the Research Council of Israel*, in addition to the *Israel Medical Journal* donated earlier. Dr. M. Kelly passes on to the library his copies of *Arthritis and Rheumatism*, *Acta Rheumatologica*, *Isis*, and occasionally other publications. During the year the Medical Society of Victoria was extremely fortunate to be offered the library of the late Dr. C. W. G. Roche. This is a valuable collection comprising over 500 volumes, including many of general and historical interest as well as medical and surgical works. Some of the latter are duplicates of books already in the library and are being disposed of to other libraries. Many will be placed in the museum book section.

Loans from the library show a marked increase on the previous year, the figures being approximately as follows: Total loans 2870, of which 2520 were to members direct, 310 to libraries in Victoria and 40 interstate. Books and journals borrowed from other libraries totalled 330, this figure also being higher than in 1959.

The appointment of a Deputy Medical Secretary to the Branch brought into prominence the inadequacy of office accommodation and made imperative some solution to the problem. After much discussion of various plans Council decided that the library would be moved out of the Medical Society Hall and the space thus made available converted into offices. The Branch owns two houses in Lansdowne Street, adjacent to Mollison House, and it is proposed to convert these to house the library. The decision was opposed by the Library Advisory Committee on the grounds that in all probability such a move could only be considered a

temporary expedient, and a resolution was forwarded to Council deplored any move other than to a permanent home. The Committee realizes that the present library layout is inefficient and cumbersome and would, in suitable circumstances, welcome the opportunity to help in the establishment of an up-to-date home for the Society's books. With this in mind and to make the best of the proposed transfer, the Committee requested Council that all planning connected with the new library be undertaken only in close collaboration with it, and it is understood that this principle has been recognized. Improved facilities and perhaps slightly easier parking are two advantages of the move from which members may hope to benefit in the long run, but the major task of transferring and rearranging the library's holding will create temporary difficulties.

BRYAN GANDEVIA,
Honorary Librarian.

Museum.

During the past twelve months the museum has continued to expand—the reference catalogue which in 1958 contained 350 items now has well over 700, and the number of books in the Australiana section is over 400. Several of these books are non-medical, but are invaluable references for socio-medical problems and early general practice. Two of the most valuable recent acquisitions are "The Historical Records of New South Wales" in 7 volumes, and John White's "Journal of a Voyage to New South Wales" (1790). The Curator frequently reviews the holdings of the second-hand booksellers in Melbourne and Sydney, and by this means a book bearing the bookplate of the Port Phillip Medical Association (1846-51) was located. A search was made of the library and museum shelves, and several books which had been in this medical library (the first in Australia) were discovered, as were library books of its immediate successor, the Victorian Medical Association. These form a display in the downstairs foyer of the B.M.A. These form a display in the downstairs foyer of the B.M.A.

Other displays have included the evolution of the stethoscope and the evolution of the sphygmomanometer, both of which were shown at the Asian-Pacific Congress of Cardiology in Melbourne in May. The sphygmomanometers are currently on display in the museum showcase, but the stethoscopes have been transferred to the museum itself, where adequate display facilities are urgently needed. Donations of old medical instruments of all types and all vintages are requested.

The museum has succeeded in acquiring printed indices to the Parliamentary papers of all States except Queensland, and is now endeavouring to obtain copies of the most interesting of the medical documents. Some from Victoria and Tasmania are already available, and an index is being prepared.

Since his return from overseas, Dr. David O'Sullivan has commenced to catalogue the museum's large collection of photographs. Dr. O'Sullivan now lives in Ballarat, and has sent the museum several interesting items connected with the medical history of that district.

It is regretted that the re-binding of some of the older books in the general museum section has not yet been possible, but temporary repairs have been made where necessary. A few of the books in the Australiana section are duplicated, and are available for exchange. Inquiries on this matter are invited, and all donations are welcome.

Donations received during the year include a set of instruments once owned by Dr. Francis Workman, sent to the museum by Dr. J. W. Saxton of Queensland after he had read an article concerning this gentleman in *THE MEDICAL JOURNAL OF AUSTRALIA*, by Dr. Bryn Thomas and Dr. Bryan Gandevia. Donations of books were received from the late Dr. Cedric Drury, the late Dr. Samuel Heald, Sir William Johnston, Professor John Bostock, Dr. Bryan Gandevia, Dr. Ivan Maxwell, Dr. Percy Zerman, and the Repatriation Department, Queensland. Donations of instruments, pictures or documents were received from Sir William Johnston, Sir Kingsley Norris, Dr. J. P. Major, Dr. I. G. MacLean and Sister I. M. Hooke.

Miss Ann Tovell, assistant to the Curator, has continued the invaluable work of indexing and filing items in the archives. It is hoped that her list of references to Australia in overseas medical journals (1788-1880) will be made available in duplicated form in due course.

BRYAN GANDEVIA,
Honorary Curator.

Reports of Subdivisions.

Metropolitan.

Western.—Office-bearers: Branch Council Representative, Dr. N. L. Dodd; Chairman, Dr. N. L. Dodd; Honorary Secretary, Dr. D. D. Coutts.

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During the past twelve months four meetings of the Subdivision were held: at Sunshine Town Hall on December 7, 1959; at 27 Nicholson Street, Footscray, on March 17, 1960; at "Edenope", Moonee Ponds, on May 19, 1960; and at the Williamstown Hospital on September 6, 1960. The meetings were well attended and copies of the minutes have been circulated to all members of the subdivision.

D. D. COUTTS,
Honorary Secretary.

Southern.—Office-bearers: Branch Council Representative, Dr. H. F. Tucker; Chairman, Dr. L. C. Brittingham; Honorary Secretary, Dr. A. Ley.

Two meetings were held during the year at which various pertinent matters were discussed.

AUSTIN G. LEY,
Honorary Secretary.

South Central.—Office-bearers: Branch Council Representative, Dr. J. Gavin Johnson; Chairman, Dr. D. J. M. Dunn; Honorary Secretary, Dr. J. S. Green.

During the last twelve months the subdivision held two meetings—an annual general meeting on December 8, 1959, at which the office-bearers were appointed and a special meeting on June 2, 1960, called to discuss the Pharmaceutical Benefits Scheme.

JOHN S. GREEN,
Honorary Secretary.

Northern.—Office-bearers: Branch Council Representative, Dr. K. E. Ratten; Chairman, Dr. S. J. Whiteside; Honorary Secretary, Dr. K. E. Ratten.

One meeting of the Subdivision was held during the year, on May 24, when the main topic for discussion was the Pharmaceutical Benefits Scheme. Several motions were passed and referred to the Branch Council for consideration.

K. E. RATTEN,
Honorary Secretary.

Maroondah.—Office-bearers: Branch Council Representative, Dr. W. E. Hewitt; Chairman, Dr. W. M. G. Leembruggen; Honorary Secretary, Dr. N. Carson.

Three meetings were conducted this year, including the inaugural meeting of the subdivision held at the home of Dr. Hewitt in February. The business of this meeting comprised discussion on the formation of an Australian Medical Association, and plans were formulated for the future conduct of meetings. There were 11 members present.

The second meeting was held in June at Mirrama Court, Mitcham, and this took the form of a special business meeting to discuss the Pharmaceutical Benefits Scheme. Thirty-two members were present.

The third meeting was held in September and was attended by 34 members. Two papers were presented and discussion followed. The first was "Fees in General Practice". A survey of fees in group practice in the subdivision was presented as a basis for discussion. A committee was formed to produce a list of fees for the guidance of subdivision members.

The second paper was "Nationalization of Medicine" and was presented jointly by Mr. F. Bishop and Dr. W. Coates. Two different aspects of future possibilities were presented.

A further meeting is planned for November. It has been decided by this subdivision to hold at least three meetings each year. The attendance, excluding the formation meeting, has been 30% of the medical population of the area.

N. CARSON,
Honorary Secretary.

North-Eastern.—Office-bearers: Branch Council Representative, Dr. Charles Roseby; Chairman, Dr. W. P. Heslop; Honorary Secretary, Dr. Charles Roseby.

Two meetings were held in 1960 in this subdivision which consists of over 140 members.

The first, to instruct the representatives to Convocation to consider the formation of the new Australian Medical Association, was attended by 13 members.

The second meeting, called to consider the contentious Pharmaceutical Benefits Scheme—despite a special request to attend, due to its importance—was attended by eight members.

CHARLES ROSEBY,
Honorary Secretary.

Peninsula.—Office-bearers: Branch Council Representative, Dr. J. F. Akeroyd; Chairman, Dr. J. F. Akeroyd; Vice-Chairmen, Dr. A. M. Hutson and Dr. C. M. Hopkins; Honorary Secretary, Dr. H. S. Moroney.

This subdivision of some 80 members, formerly part of the South-Eastern Suburban Subdivision, was constituted as from November 1, 1959.

The inaugural meeting was held on October 29, 1959, at Frankston Community Hospital, under the chairmanship of Dr. Roderick Thomson (Chairman, South-Eastern Suburban Subdivision), with 12 members attending.

Dr. J. McCarthy (Honorary Secretary, South-Eastern Suburban Subdivision) and Dr. A. W. Burton (Branch Council Representative, South-Eastern Suburban Subdivision) were also present.

At a further meeting held on January 12, 1960, the Honorary Secretary notified the election of Dr. J. F. Akeroyd as Branch Council Representative, and of Dr. C. M. Hopkins, Dr. H. M. Stevenson and Dr. J. F. Williams as representatives on Convocation.

Also at this meeting the subdivision unanimously declared itself in favour of the formation of an Australian Medical Association.

A meeting held on May 31, 1960, produced much discussion of the Pharmaceutical Benefits Scheme, the Subdivision declaring itself not in favour of the scheme as at present operating.

H. S. MORONEY,
Honorary Secretary.

Eastern.—Office-bearers: Branch Council Representative, Dr. H. G. Judkins; Chairman, Dr. J. G. McMahon; Honorary Secretary, Dr. W. Austin Cooper.

The following meetings were held during the year.

1. July 24, 1959, at St. George's Hospital: Dr. S. Ferguson and Dr. H. Hosking retired as Chairman and Honorary Secretary respectively and Dr. J. McMahon and Dr. W. Austin Cooper were elected to the positions. Dr. C. H. Dickson spoke on workers' compensation problems.

2. February 10, 1960, at Canterbury: Dr. J. McMahon was in the chair. The meeting supported the formation of the Australian Medical Association but expressed very definite views against sectional representation in the organization of the central body. The subdivision sent delegates to Convocation on this matter.

3. June 8, 1960, at St. George's Hospital: Dr. J. McMahon was in the chair. Dr. H. G. Judkins gave an address on recent developments in the Pharmaceutical Benefits Scheme. The meeting expressed dissatisfaction with the scheme and also resolved that the Branch Council should have the mandate of all subdivisions before implementation of any new policy.

W. AUSTIN COOPER,
Honorary Secretary.

South-Eastern.—Office-bearers: Branch Council Representative, Dr. A. W. Burton to June 1 and thereafter Dr. James Best; Chairman, Dr. T. R. Thomson; Vice-Chairmen, Dr. James Best and Dr. M. Lindsey; Honorary Secretary, Dr. J. E. McCarthy.

Two meetings were held during the year. The first, on December 3, 1959, was concerned with instructing the delegates to Convocation that the subdivision favoured the formation of an Australian Medical Association. The other was held to deplore the action of the Commonwealth Government in instituting the new Pharmaceutical Benefits Scheme on March 1, the Scheme itself and other matters pertaining thereto.

J. E. McCARTHY,
Honorary Secretary.

Country.

Gippsland.—Office-bearers: Branch Council Representative, Dr. D. F. Mitchell; Substitute Representatives, Dr. W. G. Birks, Dr. A. A. Crook; Chairman, Dr. J. Moore Andrew; Honorary Secretary, Dr. John E. Joseph.

On November 7, 1959, the Melbourne Medical Post-Graduate Committee conducted a course at the Traralgon and District Hospital. Lectures were given by: Dr. A. Wynn, "Hypertension"; Dr. J. R. Stawell, "Diabetes"; and Dr. Howard Williams, "Recent Advances in Paediatrics".

A post-graduate course was given at the Warragul Hospital on February 18, 1960. This consisted of a series of lectures, given by: Dr. F. M. C. Forster, "The Management of Disproportion"; Dr. A. R. Long, "Vaginal Discharge"; Dr. J. W. Johnstone "Hormones in Gynaecology"; and Dr. W. H. Kitchen, "Resuscitation in the New-Born".

On May 7, 1960, the Post-Graduate Committee conducted a very enjoyable and successful course at Sale. Lectures were given by: Dr. E. Clarke, "Modern Aspects of Pulmonary Tuberculosis"; Dr. J. L. Frew, "Nephritis"; and Dr. J. Billings, "Neurological Diagnosis in General Practice".

The subdivision held a meeting at Traralgon on May 24, 1960, to discuss the introduction of the new Pharmaceutical Benefits Scheme. Three motions were carried and copies of these were sent to the Branch Council and to members of the subdivision.

The Post-Graduate Committee presented a series of lectures at Yallourn on August 13, 1960. These were given by: Dr. R. K. Newing, "Hand Injuries"; Dr. B. Keon-Cohen, "Low Backache"; Dr. J. B. Somerset, "Recent Advances in Genito-Urinary Surgery"; and Dr. Kelvin Lidge, "The Diagnosis and Management of Common Eye Conditions".

JOHN E. JOSEPH,
Honorary Secretary.

North-Eastern.—Office-bearers: Branch Council Representative, Dr. F. R. Phillips; Substitute Representatives, Dr. K. J. Lipsut and Dr. D. M. Whittaker; Chairman, Dr. F. R. Phillips; Honorary Secretary, Dr. M. Rohan; Honorary Treasurer, Dr. H. Marks.

In October, 1959, a subdivisional meeting was held to discuss the question of an increase in fees, and the proposed 5s. charge for prescriptions. In addition the Branch Council member, Dr. F. R. Phillips, gave an outline of matters discussed at recent Council meetings.

A plebiscite conducted by post among the doctors of the subdivision to gauge the feelings of the subdivision in regard to the formation of an Australian Medical Association showed a unanimous opinion in favour.

In May, 1960, a similar plebiscite was carried out to determine the members' views on the implications and limitations of the Pharmaceutical Benefits Scheme. General dissatisfaction with the Scheme was indicated, because of its bureaucratic basis; and there was general agreement that the imposition of the 5s. charge constituted a change in principle from the preceding scheme. About one-third of the members favoured enlargement of the scheme to embrace all drugs.

Post-graduate medical lectures were held on April 2, 1960.

M. ROHAN,
Honorary Secretary.

Geelong.—Office-bearers: Branch Council Representative, Dr. V. D. Plueckhahn; Substitute Representatives, Dr. M. W. Morris and Dr. E. I. Fargie; Chairman, Dr. H. R. Millikan; Vice-Chairmen, Dr. V. D. Plueckhahn and Dr. G. C. Darby; Honorary Secretary, Mr. A. R. Waterhouse; Honorary Treasurer, Dr. J. W. Bishop; Assistant Secretary, Dr. B. H. Guaran.

The annual general meeting was held on August 10, 1960, when the new office-bearers were elected.

Four business meetings were held during the year, with an average attendance of twenty-four members. Six meetings of the full committee were held.

A special meeting was held on May 18, 1960, to discuss the Pharmaceutical Benefits Scheme. Dr. H. Judkins, Dr. H. Franklands (Commonwealth Director of Health), Mr. L. Lock (Commonwealth Pharmacist) and Dr. C. H. Dickson attended to assist in discussion and answer questions.

The sixth annual dinner-dance of the subdivision was at Aberdeen House in September. This is proving to be increasingly successful.

K. J. COLEMAN,
Honorary Secretary (past).

South-Western.—Office-bearers: Branch Council Representative, Dr. W. R. Angus; Substitute Representatives, Dr. L. T. Griffiths and Dr. B. S. Alderson; Chairman, Dr. J. K. Gardner; Vice-Chairmen, Dr. A. D. Matheson and Dr. L. T. Griffiths; Honorary Secretary, Dr. R. R. Sobey.

Four ordinary subdivisional meetings were held during the past twelve months. These took the usual form of a business meeting, lectures by visiting clinicians arranged by the Melbourne Medical Post-Graduate Committee, winding up with a dinner in the evening. The meetings were held at Portland, Terang, Colac and Warrnambool. The chief discussions in several of the meetings concerned the new Pharmaceutical Benefits Regulations. Widespread dissatisfaction was expressed with the scheme as it stands now. Alternative suggestions were discussed, and these have been forwarded to Branch Council.

A special subdivisional meeting was held in Warrnambool in February to discuss the proposed formation of an Australian Medical Association and Convocation delegates were instructed to support the move for its formation, voting being 19/4 in favour.

A Branch meeting was held in Hamilton in May. This took the form of a clinical meeting, discussion of business and medico-political matters of interest by the President and Medical Secretary, dinner, and a most interesting talk in the evening on "Psychiatry in a Penal Setting" by Dr. A. A. Bartholomew.

We are much indebted to Branch Council for arranging these Branch meetings in the country and realize the considerable time and effort put into them by Branch Council.

Our appreciation to the Post-Graduate Committee and lecturers for their contributions to the success of our meetings is also recorded.

R. R. SOBEY,
Honorary Secretary.

Ballarat.—Office-bearers: Branch Council Representative, Dr. M. H. B. Robinson; Chairman, Dr. D. A. Alexander; Vice-Chairman, Dr. Neil F. Pescott; Honorary Secretary, Dr. Ian C. Goy; Honorary Treasurer, Dr. Kingsley C. Porter.

The annual meeting was held on September 24, 1959, when the office-bearers were elected. This meeting was combined with a dinner at which Dr. L. E. Hurley was guest speaker.

During the year five local council meetings were held. Two general meetings were held; the first one to discuss the formation of the Australian Medical Association; the second to discuss the Pharmaceutical Benefits Scheme and the activities of chiropractors.

In addition four post-graduate lectures have been given during the year.

IAN C. GOY,
Honorary Secretary.

North-Western.—Office-bearers: Branch Council Representative, Dr. B. Hutton-Jones; Substitute Representatives, Dr. A. Hinchley and Dr. Ross Webster; Chairman, Dr. G. Forsyth; Honorary Secretary, Dr. Ross Webster.

On December 18, 1959, a business meeting was held at Horsham to discuss the proposed formation of an Australian Medical Association. Members voted unanimously in favour of the proposal and delegates to Convocation were instructed accordingly.

A further meeting was held in conjunction with the post-graduate meeting at Warracknabeal on April 9. On this occasion the main discussion was centred on the new Pharmaceutical Benefits Scheme. Members expressed their dissatisfaction with the new regulations and Branch Council was advised accordingly.

On July 16 The Royal Australasian College of Physicians held a most successful meeting at Horsham. We were pleased to welcome seven members of the College, all of whom contributed to a most interesting discussion on selected patients. The programme concluded with an informal dinner. The meeting was well attended and all present were very appreciative of the action of the College in holding such a function.

Three post-graduate meetings have as usual been held this year, at Horsham, Mildura and Warracknabeal. These have continued to be popular and once again our thanks are recorded to the Melbourne Medical Post-Graduate Committee for arranging the lectures.

ROSS WEBSTER,
Honorary Secretary.

Goulburn.—Office-bearers: Branch Council Representative, Dr. D. F. Lally; Chairman, Dr. J. B. McKiernan; Honorary Secretary, Dr. Brian Schloeffel; Honorary Treasurer, Dr. Mark Roche.

Dr. D. G. McKellar of Mooroopna was reelected to Branch Council by the general body of members, and it is gratifying that one of our members should be so honoured. Our Branch Council representative has once again discharged his voluntary duties regularly, ably, and with good will. Both have reported at all possible opportunities to our meetings and also to groups and single individuals. We are, therefore, kept well informed of current trends and activities.

This has been one of our best and most active years.

Attendances at meetings have been excellent and the interest shown by our members in subdivisional activities has been most heartening.

Our two regular annual lectures series conducted by the Melbourne Medical Post-Graduate Committee exemplified this and the choice of lecturers on each occasion was a happy one from all aspects. Both programmes were conducted in their entirety at the Victoria Hotel, Shepparton. The matron and staff of the hospital were invited. At the

conclusion of each meeting members were joined by their wives at a dinner dance.

The lecture series was:

November 21, 1959: Professor Lance Townsend, "Maternal Mortality"; Dr. John Cahill, "Cardiac Failure". For the first time a series of films was included. These were provided by the Lederle Company and were recent releases—(i) "Aortic Grafts", (ii) "Surgery of the Adrenals". A locally produced 16 mm. colour silent film was shown in conclusion by the producer, Dr. D. G. MacKellar—"Direct Blood Transfusion—Julian Smith Technique". It was this programme which suggested new ideas for 1960.

March 19, 1960: Mr. Ken Morris, "Advances in Cardiac Surgery"; Dr. Norman Wettewall, "Endocrine Disorders in Children"; Mr. Alex Alder, "Urinary Tract Infections". The average attendance at each was 40.

January 29, 1960: (i) Special subdivisional meeting—discussion on proposed formation of an Australian Medical Association; (ii) Dr. Mark Roche, "Common Eye Conditions in General Practice"; (iii) Film, "Ocular Inflammations". Film and sequelae provided by the Pfizer Company.

April 1, 1960: (i) Symposium on hypertension; (ii) film "Chlorothiazide". Film and sequelae provided by Merck, Sharpe & Dohme International. (This meeting was most ably organized by Dr. W. Fabb, in its entirety, prior to his leaving this subdivision.)

June 10, 1960: (i) Special subdivisional meeting to discuss the Pharmaceutical Benefits Scheme; (ii) films, "Surgical Treatment of Coronary Artery Disease", "Surgical Anatomy of Breast and Axilla". Films and sequelae provided by the Sulli Company.

August 26, 1960: (i) Dr. Kelvin Lidgett, "Practical Clues on Eye Conditions"; (ii) films, "Grand Rounds—Malignant and Pre-Malignant Conditions of the Breast". Films and sequelae provided by the Upjohn Company. This night eclipsed all others to date with an attendance of 33.

Clinical film nights series: held on Friday evenings from 8 p.m. at the Victoria Hotel. Each followed by supper and refreshments. The average attendance was 26.

Future Activities: (i) Post-Graduate lecture series, November 22, 1960; Dr. John McLean, Mr. Howard Eddye, Dr. John Birrell; (ii) clinical film night, January 20, 1961. Surgical films to arrive in December, 1960, supplied by the Lederle Company. Tentative arrangements are in hand for at least three other such evenings during 1961.

BRIAN SCHLOEFFEL,
Honorary Secretary.

Reports of Sections.

Geriatric Group.—Office-bearers: Chairman, Sir William Johnston; Honorary Secretary, Dr. R. F. Butterworth; Honorary Treasurer, Dr. David Wallace.

The inaugural meeting of the Group took place on Tuesday, May 10, 1960.

A clinical meeting was held at the Geriatric Unit, Mount Royal, on Saturday, July 2, from 11.30 a.m. until 3.30 p.m., and eighteen members attended. It is anticipated that a further clinical meeting will be held at Greenvale at the beginning of November.

R. F. BUTTERWORTH,
Honorary Secretary.

The Ophthalmological Society of Australia (B.M.A.), Victorian Branch.—Office-bearers: Chairman, Dr. Edward Ryan; Treasurer, Dr. P. H. Cohen; Secretary, Dr. S. Troski.

Up to the time of this report, four meetings have been held in 1960. Two at the Victorian Eye and Ear Hospital, one at St. Vincent's Hospital and one at Prince Henry's Hospital.

Scientific: At the annual meeting the retiring Chairman, Dr. J. B. Foster, gave an illustrated address on plastic surgery of the lids. At other meetings cases of interest have been presented.

Teaching: Many members are concerned with teaching for the Diploma of Ophthalmology, in particular the series of lectures for Part II of the Diploma.

Asia-Pacific Academy of Ophthalmology: The Victorian Branch has offered to be host to the next meeting in 1964.

Organization: The Branch has accepted an amendment to its rules and has elected an Executive. During the year two representatives to Council, Dr. H. Ryan and Dr. R. Lowe, resigned. Their resignations were accepted with regret and Dr. G. Serpell and Dr. S. Troski were elected in their places. The other representative is Dr. K. G. Howsam.

1959 Meetings: Two meetings were held late in 1959. A dinner was tendered to Dr. E. Spaeth and Dr. D. Pischell.

A film evening was held featuring films from the Barraquer Clinic; these were on zonulysis and anterior chamber lenses.

S. TROSKI,
Honorary Secretary.

The Oto-Laryngological Society of Australia (Victorian Section).—Office-bearers: President, Dr. Heyworth Watson; Vice-President, Dr. R. H. Stevens; Secretary, Dr. D. F. Cossar; Treasurer, Dr. R. C. Willis; Committeeman, Dr. C. S. Richards.

Clinical meetings of the Victorian Section were held throughout the year, and the annual general meeting of the Australian Society was held in Melbourne from August 22 to 24. There was a good attendance of interstate visitors at the annual meeting and the scientific sessions also were well attended.

DAVID COSSAR,
Honorary Secretary.

Section of Preventive Medicine.—Office-bearers: President, Dr. W. Barbara Meredith; Secretary, Dr. D. W. Rankin; Committee, Dr. S. G. Anderson, Dr. J. Forbes and Dr. M. M. Wilson.

Five clinical meetings were held during the year, the following being the speakers and subjects:

October 8, 1959: "The Evolution of an Infectious Disease as Exemplified by Myxomatosis", Professor F. Fenner.

March 10, 1960: "The Preventive Medical Services Provided by the City of Brunswick", Dr. L. J. Hartman.

May 12, 1960: "The Prevention of Suicides", Dr. E. Cunningham Dax.

July 14, 1960: "Some Aspects of Preventive Medicine in Maryland, U.S.A., with Special Emphasis on Maternal and Child Welfare Work", Dr. Lois Anderson.

September 8, 1960: "Public Health in the United States", Dr. R. J. Farnbach.

D. W. RANKIN,
Honorary Secretary.

Section for the Study of Allergic Diseases.—Office-bearers: Chairman, Dr. R. H. O. Donald; Immediate Past-Chairman, Dr. P. Ward Farmer; Secretary-Treasurer, Dr. Alan Murray; Executive Members, Dr. V. G. Bristow and Dr. D. A. Prentice.

The membership of the section now stands at 24, and the average attendance at meetings has been fourteen. During the year four meetings were held, as follows:

In November, 1959, Dr. Ivan Maxwell gave a summary of the proceedings of the Fourth European Congress of Allergy.

The March meeting took the form of a panel discussion on "The Management of Allergic Problems in General Practice", in conjunction with the Melbourne Medical Post-Graduate Committee.

In May the members discussed matters concerning the Pharmaceutical Benefits Scheme.

Dr. J. C. Trinca read a paper in August entitled "The Relative Importance of Pollens in Different Districts of Australia, Based on a Review of Pollen Extracts Ordered for the Treatment of Allergic Conditions".

ALAN MURRAY,
Honorary Secretary.

B.M.A. Arts Group.—Office-bearers: President, Dr. M. C. Davis; Secretary and Treasurer, Dr. W. R. C. Bennett. Meetings are held at 8.15 p.m. on the second Thursday in the month.

This group was formed towards the end of 1959, the object being for doctors to meet in a congenial atmosphere with a common interest in the arts in general. The activities were, therefore, to comprise not only the practical aspects of painting and sculpture, but art appreciation, photography and other creative arts. How far this has been achieved, is shown in the programmes of the meetings which took place during the year. Meetings have been held at the Medical Society Hall and at the studios of artists.

In April, 1960, an exhibition of paintings by members of the group was held in the gallery of the Tasmanian Government Tourist Bureau. Paintings by the late Douglas Thomas and the late Roy Maynard were kindly lent for this exhibition.

The following meetings were held:

November 26, 1959: Demonstration of Screen Printing by Mr. Des. Norman.

December 17, 1959: "The Background of Australian Painting", by Mr. William Dargle.

February 23, 1960: "Art and Obscurity", by Mr. Ian Bow.

April 14, 1960: Talk and demonstration on the "Art of Stained Glass", by Mr. Alan Sumner, Director of the Art School of the National Gallery.

April 21, 1960: Opening of the annual exhibition by Dr. Leonard Cox, Chairman of the Trustees of the National Gallery of Victoria.

May 12, 1960: Film night, including "Man into Metal" (the sculpture of Ian Bow).

June 9, 1960: Practical demonstration of landscape painting by Mr. Max Middleton.

July 14, 1960: Illustrated talk on the "Use of Ornamental Cast Iron in Victorian Architecture" by Dr. E. Graeme Robertson.

August 11, 1960: "Aboriginal Art" by Mr. A. Massola, President of the Anthropological Society of Victoria.

It is hoped that it will be possible to maintain the high quality of presentation and wide variety of subject matter at these meetings and that the group will be able to hold an exhibition annually. The possibility of exchanging paintings for exhibition with a similar group in London is being investigated.

W. R. C. BENNETT,
Honorary Secretary.

Section of Industrial Medicine.—Office-bearers: President, Dr. W. F. Cooper; Honorary Secretary, Dr. A. J. Christopher; Honorary Treasurer, Dr. A. C. Mendelsohn; Committee, Dr. J. H. Gowland, Dr. F. N. Laidlaw, Dr. L. R. Menogue, Dr. D. L. G. Thomas, Dr. M. G. Whiteside, Dr. R. D. Wilson.

Four meetings were held during the year, as follows:

November 10, 1959: a symposium on "Heart Disease in Industry", the speakers being Dr. A. C. Mendelsohn, Dr. H. B. Kay and Mr. W. R. Leahy.

March 29, 1960: A plant walk at the new factory of the Ford Motor Company at Broadmeadows, including an inspection of the medical facilities of the factory and a talk by the Chief Medical Officer of the Company, Dr. F. N. Laidlaw, on the organization of an industrial medical service.

June 14, 1960: A discussion on "Cardiac and Respiratory Arrest—the Technique of Cardiac Stimulation and Artificial Respiration", the speakers being Mr. N. T. Hamilton and Dr. Bryan Gandevia. A film entitled "Cardiac Massage" was shown and a demonstration on the latest methods of respiratory resuscitation was given by Mr. J. Conabere, Secretary of the Elwood Life Saving Club.

August 15, 1960: A combined meeting with the Victorian Branch of the Australasian Association of Psychiatrists on the subject "The Early Recognition and Management of Alcoholism". The speakers were Dr. J. H. Hurt, Professor Marvin Block and Dr. E. W. Corless, and the discussion was opened by Dr. L. Joel.

The Edgar Rouse prize for 1960 open to entrants in Division III in Medicine at the University of Melbourne and awarded for the best essay on the subject "The Employment of the Physically Handicapped" was won by Mr. Arthur Borten, a student of the Royal Melbourne Hospital.

A. J. CHRISTOPHERS,
Honorary Secretary.

Australian Rheumatism Association (Victorian Group).—Office-bearers: Chairman, Dr. W. McI. Rose; Honorary Secretary, Dr. J. B. Webb; Honorary Treasurer, Dr. L. Wedlick; Council Members, Dr. R. F. A. Strang, Dr. F. May and Dr. G. McEwen.

On October 15, 16 and 17, 1959, the annual meeting of the Australian Rheumatism Association was held in Melbourne, and the following papers were presented: Dr. S. G. Nelson (N.S.W.), "Hypertrophic Pulmonary Osteoarthritis"; Dr. B. Haynes (N.S.W.), "Rheumatism and the Hypothalamus"; Dr. F. Drew (S.A.), "Trauma and Ankylosing Spondylitis"; Dr. P. Benjamin (N.S.W.), "Osteoporosis"; Dr. S. Milazzo (S.A.), "Osteitis Pubis"; Professor E. R. Trethewie (Vic.), "Joint-Heart Syndrome Due to the Pleuropneumonia-like Organism: A Pathological, Bacteriological and Clinical Study"; Dr. M. Kelly (Vic.), "Preliminary Observations on G27202"; Dr. N. Wing (N.S.W.), "Interesting Experiences with Chloroquine"; Dr. R. Strang (Vic.), "The Differential Agglutination Titre with Results in a Series".

A session of presentations of brief cases, etc., was held, and a visit was made to the Hampton Hospital Rehabilitation Centre.

A scientific session was held on May 4, 1960, at which Dr. John Webb presented a paper, entitled "Haemophilia and Haemophilic Arthropathy".

The annual general meeting of the Victorian Group was held on August 24, 1960, at which the office-bearers were elected. The membership of the group now numbers 23 full members.

JOHN B. WEBB,
Honorary Secretary.

Association of Salaried Medical Specialists.—Office-bearers: Chairman, Dr. David Cowling (Royal Melbourne Hospital); Honorary Secretary, Mr. Robin Lowe (Royal Melbourne Hospital); Honorary Treasurer, Dr. Herbert Newman (Royal Melbourne Hospital); Members, Dr. J. Monk (Box Hill Hospital), Dr. B. Wadham (Preston and Northcote Community Hospital).

This association was formed at an open meeting held at the Royal Melbourne Hospital on March 11, 1960, and approval of its incorporation as a special group within the Victorian Branch of the British Medical Association was granted by the Branch Council on April 27, 1960.

The aim of the association is expressed in its constitution as follows: (i) The betterment of specialist services in hospitals. (ii) The representation of the interests of salaried medical specialists in hospitals. (iii) The advancement of investigation and research in hospitals.

Membership is open to any specialist practitioner holding a salaried appointment in a public hospital whether on a whole-time or sessional basis. It is hoped that all members of the British Medical Association who qualify for membership will actively support the work of the group. An annual subscription of £1 is payable on January 1.

Initial activities of the group have been confined to the recent changes in conditions of employment of members arising from the report of the Medical Salaries Committee to the Minister of Health.

The group is pressing for revision and amendment of this report and has submitted a preliminary memorandum on the subject to the Medical Salaries Committee. A group representative has been appointed to the recently formed ad-hoc committee of the Victorian Branch on medical salaries which met the Minister of Health on July 6.

Members of the group are invited to bring to the attention of the executive committee any individual problems arising from the new terms of employment.

ROBIN LOWE,
Honorary Secretary.

Section of Medical Administration.—Office-bearers: Chairman, Dr. P. N. O'Donnell; Honorary Secretary and Honorary Treasurer, Dr. W. M. C. Keane; Committee Members, Dr. J. Hill, Dr. H. I. Gibb and Dr. J. P. Morris.

In April, 1959, the inaugural meeting was held, and the constitution was adopted at a meeting held in September, 1959. The first point of the constitution is that this section should have as its major aim the increase of interest in and knowledge of the administrative aspects of medicine. It was agreed that membership should be open to all members of the British Medical Association whose professional duties are primarily administrative.

Since November three meetings have been held and in particular the discussions during the current year have been directed at obtaining knowledge of the fundamental principles involved in administration. The other main object has been to find out the most fruitful methods of discussion. The list of meetings and the speakers were as follows:

November 26, 1959: Professor Cochrane, Sydney Myer Professor of Commerce, delivered a paper on "The Principles Involved in Administration".

March 30, 1960: Miss Rachelle Banchevska led a discussion group on "Human Relations in Groups".

July 21, 1960: Panel discussion on medical administration; chairman, Dr. P. N. O'Donnell; panel members, Dr. H. M. Franklands, Dr. K. Brennan, Dr. F. H. Wallace, Dr. I. Howard.

During the year Dr. T. M. Gilbert resigned because of transfer to West Australia, and Professor V. L. Collins on his appointment to the Chair of Child Health. It is recorded with regret that Dr. P. R. Slater died during the year.

W. M. C. KEANE,
Honorary Secretary.

Section of Medical History.—Office-bearers: President, Sir William Johnston; Honorary Secretary, Dr. M. L. Verso; Honorary Treasurer, Dr. J. Hueston; ex-officio member of Committee, Dr. Bryan Gandevia (Curator of the Museum of the Medical Society of Victoria).

Four meetings have been held since the publication of the last annual report. The programmes were as follows:

December 7, 1959: Dr. M. L. Verso presented a paper entitled "A Review of Early French Haematology".

April 11, 1960: Dr. David O'Sullivan gave a talk, illustrated by a series of lantern slides, under the general title of "In the Steps of Osler", dealing with the places associated with Osler that he had visited on his recent trip abroad.

June 27, 1960: Dr. Rachel Jakobowicz presented a paper entitled "The Hippocratic Tradition in Nineteenth Century German Medicine".

September 12, 1960: A members' night was held when books and other items of historical interest were shown by members and visitors. Contributions were made by Dr. M. Kelly, Dr. Rachel Jakobowicz, Dame Jean Macnamara, Dr. Elizabeth McComas, Dr. H. Shannon, Dr. D. O'Sullivan, and Mr. G. Roseby.

At the annual dinner held on Tuesday, August 2, the guest speaker was Sir Albert Coates who spoke on certain aspects of the life and work of Sir James Barrett.

During the year a prize of £10 was offered by the section for the best essay on a medico-historical subject by a medical student.

M. L. VERSO,
Honorary Secretary.

On behalf of the Branch Council,

H. G. JUDKINS,
President.

A. M. HUTSON,
Honorary Secretary.

C. H. DICKSON,
Medical Secretary.

This report of the year's activities of the Association would be incomplete without a word of thanks to the secretarial and office staff, who, behind the scenes, have made it all possible.

It has not been an easy year. The medico-political sphere has been active and controversial; there has been extra work involved in connexion with the formation of the Australian Medical Association; and the routine functioning of the office steadily increases. All this has been accomplished in the crowded conditions of insufficient office accommodation.

At the personal level, I would record my sincere gratitude to Dr. C. H. Dickson and Dr. A. W. Burton for their unfailing cooperation, encouragement and advice; and to Miss Corley and the staff for many kindnesses and courtesies extended to me during the year.

H. G. JUDKINS,
President.

Addendum.

The following reports are published on behalf of:

The Melbourne Medical Post-Graduate Committee.

The Melbourne Medical Post-Graduate Committee is charged with the responsibility of arranging study in any branches of medicine where the demand warrants it, and is representative of all bodies interested in post-graduate education. The Royal Colleges and other professional organizations provide some of the required training. The Post-Graduate Committee endeavours to coordinate the training provided and to make provision for training not otherwise available.

To a large extent the work of the Committee is described in the "Syllabus of Post-Graduate Facilities", which is sent to all doctors at the beginning of each year.

Courses for Post-Graduate Qualifications.—Courses in the sciences for candidates for higher degrees and diplomas were arranged with the appropriate departments at the University. In the main these courses occupied Monday and Wednesday afternoons over a six month period.

In response to a widespread demand a coaching course for the Primary F.R.A.C.S. examination was held from the middle of January to the end of February on a full-time basis. Entry to this course was limited to approximately 20 candidates, doctors from other States being amongst those attending. This course was greatly appreciated and it is proposed to hold it again next year.

A course in medicine suitable for candidates for M.D. Part II and the M.R.A.C.P. examination was conducted by the Honorary Staff at the Royal Melbourne Hospital.

A course in surgery for candidates for the Final Fellowship examination has been held by the State Committee of the Royal Australasian College of Surgeons.

The Committee has provided administrative assistance for courses arranged by the Australasian Association of

Psychiatrists and the Victorian Branch of the Ophthalmological Society of Australia.

Refresher Courses.—On two occasions, general refresher courses in medicine and surgery were held over a period of a week, the honorary staff of the Alfred Hospital providing the first and the honorary staff of St. Vincent's Hospital arranging the second for the Committee.

Refresher courses in obstetrics and gynaecology were held in February and September at the Royal Women's Hospital, each over a period of two weeks.

The staff of the Royal Children's Hospital held a post-graduate week at the end of August, attended by school medical officers and many other doctors, with the administrative assistance of the Post-Graduate Committee.

Country Courses.—As in previous years, 25 week-end courses were held throughout the year in various country centres.

Cancer Education.—With the financial assistance of the Anti-Cancer Council, the Committee is carrying on a programme of education of the profession in cancer. A symposium on "Cancer of the Stomach" was held in April, and a further symposium on "The Reticuloses" has been arranged for October 22. In addition many lecturers in country week-end courses have dealt with cancer topics.

Overseas Lecturers.—The following visitors from overseas gave lectures for the Committee: Dr. C. W. M. Whitty, of Oxford; Professor John McMichael, of London; Dr. Wallace Brigden, of London; Dr. Hattie Alexander, of New York; Professor Clement Finch, of Harvard; Dr. Manuel Ledermann, of London; Professor Bryan McFarland, of Liverpool; Professor S. L. Israel, of Pennsylvania; Professor J. C. Goliher, of Leeds; Professor William Dameshek, of Boston; Mr. Norman Tanner, of London; Professor James Dauphinee, of Toronto; Professor A. G. R. Lowden, of Newcastle-upon-Tyne; Professor F. G. Young, of Cambridge; Dr. Ross Robertson, of Vancouver.

Recorded Lectures.—With the financial support of Nicholas Pty. Ltd., the Committee has continued to make recordings of lectures. These recordings, on microgroove discs, usually with 35 mm. slides, are available to groups of doctors or individuals on application to the Committee.

Post-Graduate Education Conference.—The first Australian Post-Graduate Education Conference was held in Sydney from August 10 to 12. This was attended by about 150 doctors from Australia and New Zealand. The Conference was arranged by the Australian Post-Graduate Federation in Medicine and the proceedings will be published at an early date.

Colour Television.—Demonstrations of the use of colour television in post-graduate medical education were provided by the firm of Smith, Kline and French, at the end of August and the beginning of September. Six two-hour sessions of operative and clinical demonstrations were telecast from the Royal Melbourne Hospital to audiences, firstly in the Melba Hall and, later, in the Public Lecture Theatre at the University. Arrangements for the programmes were made by the State Committee of the Royal Australasian College of Surgeons and the Post-Graduate Committee. Large numbers of doctors attended these sessions.

Training for Doctors from South-East Asia.—To an increasing extent the Committee is receiving requests for the provision of training for doctors from South-East Asia, in various branches of medicine and surgery.

In the main, these requests come from the Department of External Affairs, dealing with doctors who come to Australia with assistance under the Colombo Plan. The Committee is undertaking at present a survey of what training can be made available to these doctors.

Summary of Training.—The following figures indicate the number of doctors who have availed themselves of the facilities offered by the Committee in 1960:

Total number of enrolments for courses and clinics ..	935
Numbers attending courses for higher qualifications ..	147
Numbers attending country courses (on reports received) ..	180
Numbers attending metropolitan refresher courses ..	117
Number of individual doctors who have attended lectures by overseas visitors ..	159
Number of doctors for whom the Committee has arranged training overseas ..	43
Number of doctors attending cancer instruction ..	408
Annual subscribers ..	596

Acknowledgements.—The Committee thanks the lecturers who took part in its courses during the year. It also

expressed thanks to the deans and members of the clinical schools of the teaching hospitals and to members of the departments of the University of Melbourne for their assistance in carrying out the programme for 1960. It is also grateful for various donations made by members of the profession. The Committee thanks Nicholas Pty. Ltd. for financial help in the recording of lectures, Parke-Davis for the printing of diary cards and Smith, Kline & French for the demonstration of the use of colour television.

The British Medical Insurance Company of Victoria Ltd.

The annual report of the company, over the signature of Sir William Johnston, was submitted to an ordinary general meeting held on July 11, 1960. The following is a summary of the report:

The Directors have pleasure in submitting for your approval the balance sheet, profit and loss account and appropriation account for the twelve months ended April 30, 1960.

The results of the year's operations have not, in the opinion of the Directors, been materially affected by any items of an abnormal character. The total premiums written for the year were £134,709, as compared with £124,867 last year. Net profit for the year was £12,572 11s. 7d. after providing £6300 for taxation. The appropriation account shows that £1575 was allocated during the year to various institutions connected with the medical profession.

Up to date the company has given books to the value of £3205 and £16,405 in cash to the Medical Society of Victoria, and more than £5624 to various sub-branches of the British Medical Association and other institutions connected with the medical profession. It has also taken up debentures of the Medical Society to the value of £2500, upon which it is accepting interest at the rate of only 1% *per annum*, which, of course, saves the Medical Society a considerable sum in interest.

The company has made the following loans to the Medical Society of Victoria: £3150 to finance a building purchase; £2200 to finance the purchase of an estate agency; and £10,000 to finance the purchase of property at 15-17 Lansdowne Street, East Melbourne.

The Directors feel that members of the British Medical Association will be interested to know of the benefits they have received through the activities of the company.

British Medical Agency (Victoria) Proprietary Limited.

The British Medical Agency enjoyed another successful year with the gross earnings only slightly less than the 1959 record. Expenses, however, were higher, resulting in a reduced net profit.

The provision of *locum tenentes* continues to be the most frustrating part of agency work, and country practitioners, particularly, had yet another most unsatisfactory year as far as obtaining relief was concerned.

General practices changed hands and many new practices were started in the newer suburbs.

Conflicting views exist on the valuation of goodwill of a practice, but despite the best arguments of accountants, who suggest higher figures, the final selling price is confirmed by the shortage of buyers, and the incidence of taxation. It is only rarely that a practice is sold at more than £3500 (and then often on terms). The paradoxical situation occurs when a single-handed practice grossing £10,000 is sold for £3500, yet a half-share in the same practice can be sold for £3000.

During the year some additional professional buildings were included with those for which the British Medical Agency is managing agent, and the agency now has a very satisfactory income from commission on rent collections.

The demand for specialist rooms is not nearly so great and prospective tenants are much more selective than in recent years.

INSTALLATION OF PRESIDENT FOR THE ENSUING YEAR.

The chair was vacated by Dr. H. G. Judkins, who installed Dr. G. Newman-Morris as President for the ensuing year. Dr. Newman-Morris thanked the members for his election.

PRESIDENT'S ADDRESS.

Dr. Judkins then delivered the retiring President's address (see page 353).

APPOINTMENT OF AUDITORS.

Messrs. J. V. M. Wood and Company were appointed auditors for the ensuing twelve months.

VOTES OF THANKS.

On behalf of the Branch, Dr. F. L. Davies moved a vote of thanks to the retiring members of Council—Dr. W. E. Hewitt, Dr. W. E. King and Dr. B. K. Rank.

NEW SOUTH WALES BRANCH: SCIENTIFIC.

A MEETING of the New South Wales Branch of the British Medical Association was held on August 18, 1960, at the Robert H. Todd Assembly Hall, British Medical Association House, 135 Macquarie Street, Sydney. Dr. B. A. Cook, the President, in the chair.

The Care of the Aged.

Dr. J. G. RADFORD read a paper entitled "Management of the Aged Patient" (see page 362).

Dr. A. T. EDWARDS read a paper on the psychiatric care of the aged patient. This paper has not been made available for publication.

Dr. GARNET Ross, in opening the discussion, said that Dr. Radford's suggestion that the aged could be grouped into early, middle and advanced aged was an interesting one, because such a classification gave an indication of what should be done for the individual—for example, full nursing attention in an institution, a limited amount of supervision and assistance in their own homes, and for the first group the finding of suitable employment and the maintenance of the individual's interest and self-respect. Dr. Ross said that a patient had recently come under his notice who would fit into the last-mentioned group. He was an elderly bachelor without any known relatives, living in a room alone, but still going to work which did not require skill or responsibility. Feeling a little off colour and lonely, he visited the local doctor, who advised him to give up his job. The man became very depressed, because by giving up his job he lost the only interest left to him. Dr. Ross said that that advice in his opinion was very bad.

Dr. Ross went on to say that it was easy to see the change brought about by age in others, but the change was often not appreciated in oneself. Those people were wise who appreciated the change in themselves and made preparations accordingly. Such a one was the woman who told him that she had kept her own home, but realized that the time would come when she would not be able to carry on alone. She arranged and paid for the cost of a dwelling within an organization, so that when the time came she could live there and be looked after, and ultimately the dwelling would become the property of the organization. Dr. Ross said that the papers read had been particularly interesting to him, because to his belief it was ten years since papers on the subject had been read at a similar Branch meeting in New South Wales and published in *THE MEDICAL JOURNAL OF AUSTRALIA*. It had been pointed out then that of the three groups in the community—the pre-working age group, the working age group and the past-working age group—the middle group had to support the other two. The ratio of the first to the second remained fairly constant, but for some years the third group had been gradually becoming more disproportionate by its steady increase, and therefore a greater burden to the middle group. It was to the management of the third group that attention would have to be given in the future. That had been well illustrated by the two papers read.

Dr. J. M. LAST said that anyone interested in social medicine could speak for a long time on the problems of old age without repeating anything that had been said so far. The pattern of family life in urban society at the present time had added to the medical difficulties of old age in several ways. Families were smaller than they used to be. The extended family system, a modified form of which existed in Western countries until about three generations ago, still existed among the peasant immigrants from southern Europe, and for that reason the disposal of the elderly and the infirm was seldom a major problem in that enlarging section of the Australian community. But the great majority of urban families were too small to include a member or members who had the time—and patience—to care for their elderly dependants. Families were also more mobile than they used to be, both physically and socially, and sometimes resented the old grandpa who appeared to be a millstone around their necks or a social gooseberry of whom they felt vaguely ashamed. That situation encouraged an attitude epitomized by the question "Well, what do we pay taxes for, anyway?" and many people found it easy to justify to their conscience the shifting of responsibility.

the cutting of the ties of love and affection which allowed them to commit the old people to an institution. Dr. Last said that when his patients had attempted to justify such a move by claiming that their children suffered by contact with grannie, who had "gone a bit ga-ga", he had sometimes been able to convert them to his belief that it was very good for both young and old to be exposed to each other; the young learned consideration and tolerance, and the old could relive and recapture the joys of their childhood, even when in their second childhood themselves.

Dr. Last went on to say that an increasing number of the elderly lived alone. The figure of 10% had recently been obtained at a Melbourne out-patient department, and most of those people were living alone in bed-sitting rooms or small flats, looking after themselves as best they could. When they were immobilized by bunions, shaky knees, and living upstairs (far more of a problem in Sydney than it was in his practice in Adelaide), one often wondered whether they were adequately fed. A week previously he had had the opportunity of asking Professor Eric Saint if his studies in Perth had revealed a significant degree of malnutrition or undernutrition in the elderly. Dr. Last said that, rather to his surprise, they had not; but then, Perth was well known to be such a warm-hearted place that old people were probably better cared for there than in most places. "Meals on wheels" had relieved much misery, but even more perhaps was prevented by the kindness of neighbours and tradespeople.

When admission to an institution became necessary, the quality of the available institutions in Adelaide had often worried him, and he did not doubt that the same problems arose in Sydney. Richard Asher, who had already been mentioned at the meeting, had recently drawn attention to the existence of an "institutional neurosis", and the possibility of that would make him even more reluctant to uproot people from a familiar environment, however unsatisfactory it might be.

DR. ADRIAN PAUL put forward the concept of a day centre, which he said was one of the big answers to the management of the aged and the handicapped aged. It was manned by a social worker and an occupational therapist, and transport was provided to bring those people to the centre on five days a week. A programme was arranged which provided for entertainment and useful activities; it was even possible to have some sheltered workshop activities by which a little money could be earned. It had the great advantage that the person who cared for them in the home was released to go to work. A good meal was served in the middle of the day, and it worked out very economically. The present move on the part of the municipal councils to develop senior citizens' clubs could incorporate day centres; that would be a very useful move in caring for the aged without moving them from their homes into institutions. Dr. Edwards had mentioned the over-protective daughter who did not let her mother or grandmother do anything around the house. Dr. Paul said that the basic problem was the difficulty of letting them do anything, because they were so slow. The real adjustment in the younger members of the family was to make allowances for the slowness. Dr. David Ross had pointed out that repeated unreleased aggression was a big factor in the development of hypertension, which led to strokes. One thing to remember was that the aggression was a basic characteristic which the patient had always had, and was still often present after the stroke, hindering management.

DR. W. B. GRANT referred to Dr. Edwards's comments on the frequent effectiveness of relatively simple counselling. He said that there seemed at times a tendency for some psychiatrists to think that changes could be produced only by prolonged psychotherapy. Those who had been in general practice realized the value of simple counselling. Dr. Grant finally expressed regret that Dr. Edwards regarded the viewing of "Westerns" as a regressive phenomenon.

DR. E. T. HILLIARD said that the medical profession was beginning to realize that the place for the old person was not necessarily the mental hospital. It was a community problem with a social interest right through. One fact that was probably not fully realized was that a proportion of aged ill patients (8% to 10%) recovered, and were able to return to their families. However, one was then likely to be met with the statement that the patient's room had been let. Reeducation of the families was necessary. From the psychiatrist's point of view, what the medical profession had formerly regarded as a late result of old age for which nothing could be done was nothing of the sort. Help could come from the medical profession, from the social worker and from the community generally.

DR. N. LARKINS referred to the geriatric hospital at Bodington, Wentworth Falls. Bodington had formerly been a Red Cross chest hospital, but had some years previously been converted into a geriatric hospital. Dr. Russell Godby, the superintendent, had displayed great initiative in the transformation, and had installed much equipment of geriatric importance and had made many other contributions to the intellectual and physical comfort of the inmates. Dr. Larkins mentioned that Dr. Godby liked to welcome any interested persons who wished to see what work was being done there.

DR. COOK, from the chair, said that he had enjoyed the papers. He had been interested in Dr. Radford's remarks about the relativity of old age. He himself had read about a married couple in the United States, both doctors, the husband aged 93 years and the wife 86, both in general practice. The wife went round in the car doing the necessary visiting. Dr. Cook stressed again the old person's need to belong, to be loved; otherwise he got the feeling that he was no use, but just a nuisance.

ANNUAL MEETING, AUCKLAND, FEBRUARY, 1961.

THE annual meeting of the British Medical Association was held in Auckland, New Zealand, from February 6 to 10, 1961, in conjunction with the biennial meeting of the New Zealand Branch.

Opening Ceremony.

The meeting was opened by the Governor-General of New Zealand, Lord Cobham, in the Auckland Town Hall on the morning of February 6, 1961, in the presence of some 800 doctors, doctors' wives and prominent citizens. Lord Cobham stressed the importance of balancing technical knowledge to produce whole men and women able to tackle the difficult problems of living on an ever broader front. Speaking of the considerable progress that had been made in medical knowledge, he pointed out that in medicine, no less than in the field of nuclear physics, power had to be constantly allied to wisdom and discretion. The greatest single problem that lay ahead was that of over-population. The solution that was needed was one that would be acceptable to mankind in general, one that not only was related to social problems but was in the framework of philosophy and ethics. Lord Cobham, in his address, paid a tribute to two great New Zealanders, Sir Harold Gillies and Sir Archibald Macindoe, both of whom had died within the previous year.

The retiring President of the New Zealand Branch, Dr. D. C. Low, read a message of goodwill from the Prime Minister of New Zealand, the Right Honourable Keith Holyoake. He also welcomed to the meeting the Mayor of Auckland, Mr. D. M. Robinson.

Dr. Low inducted Mr. F. B. Furkert as President of the New Zealand Branch, and insignia of office were presented to Dr. J. R. Dawson, Chairman of the Council of the Branch, and to Dr. J. E. W. Raine, Honorary General Secretary of the Branch.

Mr. Furkert presented to the Parent Body of the British Medical Association on behalf of the New Zealand Branch a large silk banner embroidered with the New Zealand coat of arms. This was received by the retiring President of the Association, Sir Arthur Porritt. The Chairman of Council of the New Zealand Branch, Dr. J. R. Dawson, presented to the President of the Council of the Association, Dr. S. Wand, an inscribed maul as a gift from the New Zealand Branch.

The inaugural address was delivered by Professor E. G. Sayers, Dean of the Otago Medical School. This is to be published in full in the *British Medical Journal*.

One Hundred and Twenty-Ninth Annual General Meeting.

The one hundred and twenty-ninth annual general meeting of the Association was held in the Town Hall, Auckland, at 8 p.m. on Monday, February 6, 1961.

At the invitation of the President of the New Zealand Branch, Mr. F. B. Furkert, a welcome was extended to the guests by the Minister of Health, Mr. N. L. Shelton, and the Mayor of Auckland, Mr. D. M. Robinson.

In a happy ceremony, Sir David Smith, Chancellor of the University of New Zealand, conferred the honorary degree of Doctor of Laws upon the President of the British Medical Association, Sir Arthur Porritt.

The annual general meeting of the Association was then formally convened, and Sir Arthur Porritt took the chair.

After the necessary formalities he installed Sir Douglas Robb as President of the British Medical Association, and Lady Porritt invested Lady Robb with the President's Lady's Badge. Dr. S. Wand, Chairman of the Council of the Association, proposed a vote of thanks to the retiring president, Sir Arthur Porritt. He pointed out the unique set of circumstances by which Sir Arthur had been simultaneously President of the British Medical Association and President of the Royal College of Surgeons of England. Dr. Wand then introduced to the President delegates from kindred associations in nine different countries.

Sir Douglas Robb then delivered his presidential address, which has been published in full in the issue of the *British Medical Journal* of February 11, 1961, and to which we refer elsewhere in this issue (see page 373). Dr. A. Talbot-Rogers, Chairman of the representative body, proposed a vote of thanks to Sir Douglas Robb.

The meeting was then adjourned until July 20, 1961, at Sheffield, England.

Scientific Sessions.

A comprehensive scientific programme of high standard, to which contributions were made by both local and visiting medical practitioners, occupied most of the time of the meeting. Plenary sessions dealt with the following subjects: "Maintaining the Health of the Middle-Aged Executive", "The General Surgical, Medical and Psychological Problems of Pregnancy", "Chemotherapy in Cancer", "Iso-Immunization—A New Concept of Disease", "Mental Health in the Community".

Round table conferences were devoted to the present position of steroid therapy, ulcerative colitis and thyroid disease.

Sectional meetings were held by the sections of anaesthesia, dermatology, general practice, medicine, neurology and neurosurgery, obstetrics and gynaecology, ophthalmology, orthopaedic surgery, oto-rhino-laryngology, paediatrics, pathology, psychiatry, radiology, rheumatology and surgery.

Social Programme.

An extensive social programme included a motor-yacht trip on the Auckland Harbour, a dinner, a ball, a garden party and a reception at Ellerslie Racecourse.

Church Services.

The official service was held in St. Mary's Cathedral, Auckland, on the morning of February 5. The preacher was the Bishop of Auckland, the Right Reverend E. A. Gowing, and lessons were read by Dr. D. C. Low and Sir Arthur Porritt.

A special mass was said in St. Patrick's Cathedral. Archbishop J. N. Liston was the celebrant.

A service in St. David's Presbyterian Church on the evening of February 5 was conducted by the moderator of the Auckland Presbytery, the Reverend O. T. Baragwynath. Sir Douglas Robb read the lesson.

At a special service at the Auckland Synagogue on Saturday, February 4, the sermon was preached by Rabbi Alexander Astor.

Exhibitions.

A scientific exhibition attracted a total of 18 exhibits. These provided a comprehensive picture of medical research and other aspects of medical science in New Zealand.

At the exhibition of pharmaceutical products, surgical instruments and appliances, 42 firms were represented.

There were also specially arranged exhibitions at the Auckland War Memorial Museum and the Auckland City Art Gallery and an exhibition of native medicinal plants.

Out of the Past.

LEPROSY IN NEW SOUTH WALES.

[From the *Australasian Medical Gazette*, March 20, 1902.]¹

THE report of the President of the Board of Health on leprosy in New South Wales has just been published. From it we learn that on 1st January, 1900, thirteen persons remained under detention at the lazaret. During the year

but one person, a Chinese, was admitted to the lazaret under warrants, after careful enquiry into his case. Three patients died during the year; all were natives of New South Wales and of European descent. Thus the number remaining in the lazaret on 31st December, 1900, was eleven persons: five were natives of New South Wales of European descent, one was a European native of Fiji, and one was a native of the United States of America, one was a Javanese, one an aboriginal of Tanna, and two natives of China. The total number of persons admitted since 1883, when patients first began to be received (although the notification of leprosy was first made compulsory, and the detention of lepers provided for by law only towards the end of 1890), is 69. Every opportunity is given to members of the medical profession to visit the lazaret for the purpose of seeing such patients as were formerly under their care, and for the study of the disease. The cost of maintenance of the lazaret has been £154 0s. 3d. per inmate per annum. We are glad to learn that one inmate, a case of stationary nerve leprosy, with no open sores, has been released during the year from the lazaret, on condition that he presents himself from time to time for medical examination.

Correspondence.

THE BABY'S BIRTHRIGHT: A PLEA FOR A RETURN TO EXTERIOR GESTATION AND BREAST FEEDING.

SIR: I hope that all medical graduates and all thinking men and women will join me in supporting the President of the Queensland Branch of the British Medical Association in his plea for a return to breast feeding (MED. J. AUST., February 18, 1961.) I believe that the loss of this, the most basic of instincts for the preservation of the species, constitutes a danger to the future of mankind far greater than that from atomic radiation and guided missiles. Surely it must be a grave step towards extinction when one mammalian species comes to depend on another to provide food for its young.

It is sad to note that the forsaking of the breast as a functional gland has proceeded most rapidly in those nations which the Free World looks to as its leaders—Great Britain and the United States. Sadder still is the thought that so many women are renouncing the most exquisite of human pleasures.

Yours, etc.,
SUSAN F. HEPBURN.

100 Stanhope Road,
Killara,
New South Wales.
February 28, 1961.

F.O.C.L.A. WEEK, 1961.

SIR: I am reliably informed, but I find it hard to believe, that there are people whose only interest in your estimable column is the correspondence column. If this is so, then I must reach them through it to tell them that they can and should resume their post-graduate education. Where? At Goulburn from March 20 to 24, when F.O.C.L.A. will be holding its tenth annual post-graduate week. There are still sufficient hotel and motel bookings available for last-minute registrations. You owe it to your loyal letter readers, Mr. Editor, to publish this one.

Yours, etc.,
B. W. COOMBS,
Course Secretary.
February 26, 1961.

HYPERTENSION AND LIFE ASSURANCE.

SIR: In reference to Dr. W. J. McCristal's letter (MED. J. AUST., February 25, 1961) re hypertension and life assurance, could I, through your columns, ask him to enlarge further on these extracts: "... whilst we as doctors, often in good clinical faith, continue to fudge and fabricate blood-pressure readings. . . ."; and "Pending such time when an inexpensive and objective method of recording the blood pressure is devised, the task might be better left to technicians".

Yours, etc.,
J. WOOLNOUGH.

35 Oxford Street,
Epping,
New South Wales.
February 25, 1961.

¹ From the original in the Mitchell Library, Sydney.

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Notes and News.

Coastal Meat Shipments.

The Commonwealth Minister for Health, Dr. D. A. Cameron, recently announced that the Government had decided to relax the animal quarantine regulation which required that ships transporting Australian meat from one Australian port to another must have no overseas meat aboard. Dr. Cameron said that the prohibition had been applied as a precaution to prevent the introduction of disease. The requirement occasioned inconvenience because it precluded the carriage of Australian meat between ports if any overseas meat was on board, even as ships' stores. Experience showed that the difficulty could be met by requiring that the Australian meat to be shipped between ports should be carried in a cleaned and sealed chamber, apart from any other meat. It was considered that no risk of introduction of disease would be involved if that requirement was strictly enforced.

Malaria Eradication.

Progress has been made, both in quantity and quality, towards the goal of malaria eradication. At the 14th World Health Assembly held recently in New Delhi, a joint meeting of the two main committees of the Assembly received a report which states that out of 1336 million people in currently or formerly malarious areas, 298 million (22.3%) are now living in areas where malaria has been eradicated, while over 612 million (45.9%) are covered by malaria eradication programmes. Preliminary malaria eradication activities (pre-eradication surveys and pilot projects) are now under way in areas containing a population of 170 million (12.7%). A population of 255 million (19.1%) is still living in areas where no eradication scheme has been planned.

The report points out that a number of malaria eradication programmes have not progressed according to schedule, for technical, operational or administrative reasons, and "experience has shown that while it is relatively easy to find solutions to technical and operational shortcomings, it is much more difficult to correct administrative imperfections".

In the African region, results of well-planned pilot projects show that it is technically feasible to interrupt transmission

in tropical Africa despite the very intense transmission of the disease. Thus future campaigns can be planned in a more logical manner and the errors and pitfalls of the past avoided. In the region of the Americas, there has been considerable progress in most programmes, and prospects for the attainment of eradication are hopeful. In the Eastern Mediterranean region, the majority of countries have made progress, notably in the six forming the northern geographical block: Iran, Iraq, Israel, Jordan, Lebanon and the Syrian province of the United Arab Republic. Nomadism, one of the main technical problems, is an accepted way of life in Saudi Arabia, Yemen and Somalia, and to a lesser extent in Iran, Ethiopia and the Sudan. In view of the advances in the state of the eradication campaign in continental Europe, it is felt that the consolidation phase here will be reached everywhere by the end of 1962. Progress is not uniform in the South-East Asia region. The largest single malaria eradication programme in the world is in India, where a recent evaluation has indicated that although there is considerable decline in the rate and the over-all picture may appear satisfactory, there are places where the infection still is highly prevalent. In the Western Pacific region, all countries have agreed in principle to malaria eradication, but only in two are plans fully worked out. In some countries, malaria has disappeared or has become negligible. In this region trials with medicated salt have been put into operation in Netherlands New Guinea and Cambodia. An attempt to control mosquito larvae by biological means, with the introduction of a parasitic fungus, is in operation in the Tokelau Islands.

The two committees discussed measures to ensure the financing of malaria eradication programmes in the future. A number of proposals were advanced, and the meeting elected a working party composed of France, the United Kingdom, U.S.S.R., U.S.A., Central African Republic, Argentina, Iraq, Pakistan, Nigeria, India, Australia and Czechoslovakia to study and report on this question.

British Drug Exports in 1960.

Exports of British drugs and medicines reached the record figure of more than £44,000,000 sterling in 1960, an increase of £3,400,000 sterling over 1959, according to figures published by the Board of Trade. Well over a quarter of the United Kingdom pharmaceutical industry's production is exported.

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED FEBRUARY 4, 1961.¹

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	..	1(1)	..	..	..	..	..	..	1
Anobiasis
Ancylostomiasis	4	4
Anthrax
Bilharziasis
Brucellosis
Cholera
Chorea (St. Vitus)
Dengue
Diarrhoea (Infantile)	7(6)	19(16)	1(1)	..	..	..	1	..	28
Diphtheria	1
Dysentery (Bacillary)	..	1(1)	..	..	1(1)	..	..	..	2
Encephalitis	1(1)	..	..	..	..	..	1
Filariasis
Homologous Serum Jaundice
Hydatid
Infective Hepatitis	115(53)	75(44)	10(1)	46(17)	7(6)	1(1)	4	4	262
Lead Poisoning
Leprosy
Leptospirosis	1(1)	..	..	..	..	..	..
Malaria
Meningoococcal Infection
Ophtalmia
Ornithosis	1(1)	..	..	..	..	1
Paratyphoid
Plague
Pollomyelitis	..	4(2)	1	..	..	2(1)	..	..	7
Puerperal Fever
Rubella
Salmonella Infection	28(28)	..	..	..	36
Scarlet Fever	6(3)	..	..	4(4)	..	..	7
Smallpox	1(1)	..	..	..
Tetanus
Trachoma	3(3)	..	..	3
Trichinosis
Tuberculosis
Typhoid Fever
Typhus (Flea-, Mite- and Tick-borne)
Typhus (Louse-borne)
Yellow Fever

¹ Figures in parentheses are those for the metropolitan area.

Australia (£4,000,000 sterling), Nigeria, Pakistan (£2,400,000 sterling), the Irish Republic (£2,000,000 sterling), and New Zealand (£2,000,000 sterling), were the five leading importers, followed by Canada, South Africa and the United States (each £1,500,000 sterling), Ghana (£1,400,000 sterling), India (£1,300,000 sterling) and Burma (£1,000,000 sterling). Exports to common market countries (excluding Luxembourg) were £3,400,000 sterling, as compared with £2,700,000 sterling in 1959. Over half the export trade is accounted for by miscellaneous proprietary medicines (£12,800,000 sterling), antibiotics (£8,600,000 sterling), and vitamins (£2,700,000 sterling). Sales of over £12,000,000 sterling were recorded for alkaloids, anti-malaria drugs, aspirin, sulphonamides and hormones; and over £500,000 sterling for antihistaminics, barbiturates and insulin.

The Royal Australasian College of Physicians.

VICTORIAN STATE COMMITTEE.

THE Victorian State Committee of The Royal Australasian College of Physicians announces that a symposium on "The Use of Radioactive Isotopes in Medicine" will be held at the Alfred Hospital, Melbourne, on Saturday, March 25, 1961, from 11.30 a.m. The programme is as follows: "Characteristics of Isotopes", Mr. K. L. Biggs; "Radiation Protection Problems in the Use of Radioisotopes in Medicine", Mr. D. J. Stevens; "The Use of Radioactive Chromium and Iron in Haematology", Dr. G. C. de Gruchy; "Radioactive Cobalt in Haematology", Dr. I. S. Epstein; "¹⁴C Isotopes in Intermediate Metabolism", Dr. J. Bornstein; "¹³¹I in the Diagnosis of Thyroid Disease", Dr. G. Cooper; "Radioactive Isotopes in the Therapy of Malignant Disease", Dr. W. P. Holman. All members of the medical profession are invited to be present.

Medical Practice.

NATIONAL HEALTH ACT.

THE following notice is published in the *Commonwealth of Australia Gazette*, No. 19, of February 23, 1961.

NATIONAL HEALTH ACT, 1953-1959.

Notice in Pursuance of Section 134-A.

Notice is hereby given that, the Medical Services Committee of Inquiry for the State of New South Wales, after investigation, having reported on the 12th day of January, 1961, concerning the conduct of Samuel West Cook, of 167 Harris Street, Pyrmont, a medical practitioner, in relation to his provision of medical services under Part IV. of the National Health Act 1953-1959, I, Donald Alastair Cameron, Minister of State for Health, did on the second day of February, 1961, reprimand the said Samuel West Cook.

Dated this second day of February, 1961.

DONALD A. CAMERON,
Minister of State for Health.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Harrison, Owen Michael, M.B., B.S., 1959 (Univ. Sydney), Repatriation General Hospital, Concord.
Lloyd, Bruce Logan, M.B., B.S., 1960 (Univ. Sydney), Ryde District Soldiers' Memorial Hospital, Eastwood.

Deaths.

THE following deaths have been announced:

LYALL—John Angus Lyall, on February 24, 1961, at Sydney.

RAMSAY—Hugh Thomson Ramsay, on February 26, 1961, at Launceston, Tasmania.

PRIESTLEY—Henry Priestley, on February 28, 1961, at Sydney.

Diary for the Month.

MARCH 11.—Western Australian Branch, B.M.A.: Annual General Meeting.
MARCH 14.—New South Wales Branch, B.M.A.: Medical Politics Committee.
MARCH 15.—New South Wales Branch, B.M.A.: Hospitals Committee.
MARCH 15.—Victorian Branch, B.M.A.: Branch Meeting.
MARCH 16.—Victorian Branch, B.M.A.: Executive Meeting of Branch Council.
MARCH 16.—New South Wales Branch, B.M.A.: Clinical Meeting.
MARCH 21.—New South Wales Branch, B.M.A.: Council Quarterly.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

South Australian Branch (Honorary Secretary, 80 Brougham Place, North Adelaide): All contract practice appointments in South Australia.

Editorial Notices.

ALL articles submitted for publication in this Journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations, other than those normally used by the Journal, and not to underline either words or phrases.

Authors of papers are asked to state to the Editor in the title their principal qualifications as well as their relevant appointment and/or the unit, hospital or department from which the paper comes.

References to articles and books should be carefully checked. In a reference to an article in a journal the following information should be given: surname of author, initials of author, year, full title of article, name of journal, volume, number of first page of article. In a reference to a book the following information should be given: surname of author, initials of author, year of publication, full title of book, publisher, place of publication, page number (where relevant). The abbreviations used for the titles of journals are those of the list known as "World Medical Periodicals" (published by the World Medical Association). If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full data in each instance.

Authors submitting illustrations are asked, if possible, to provide the originals (not photographic copies) of line drawings, graphs and diagrams, and prints from the original negatives of photomicrographs. Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary is stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2-3.)

Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this Journal. The management cannot accept any responsibility or recognize any claim arising out of non-receipt of journal unless such notification is received within one month.

SUBSCRIPTION RATES.—Medical students and others not receiving THE MEDICAL JOURNAL OF AUSTRALIA in virtue of membership of the Branches of the British Medical Association in Australia can become subscribers to the Journal by applying to the Manager or through the usual agents and booksellers. Subscriptions can commence at the beginning of any quarter and are renewable on December 31. The rate is £6 per annum within Australia and the British Commonwealth of Nations, and £7 10s. per annum within America and foreign countries, payable in advance.

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¹ Read Victoria